Department of Otolaryngology-Head & Neck Surgery

We appreciate your cooperation in completing this form.

Physician you are seeing:	**Appointment date**:

PATIENT INFORMATION

Last name:	**First**:	**Middle Initial**:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	**Birth Date**:	**Sex**: ❑ M ❑ F
Street Address/PO Box:	**City**:	**State & Zip Code**:
Email address:	**Social Security:**	
Cell/Mobile phone: ( )	**Home Phone**: ( )	**Work Phone**: ( ) **Ext**:
Employer Name:	**Employer Address**:	**Occupation**:
* **Pharmacy Name**:	**Pharmacy Address**:	
Pharmacy Phone: ( )	**Pharmacy Fax**: ( )	

NYS LAW, ALL PRESCRIPTIONS MUST BE SENT ELECTRONICALLY TO YOUR PHARMACY
PLEASE PROVIDE THE PHARMACY'S CONTACT INFORMATION

REFFERAL SOURCE

Referring Source (Please check all that apply): ❑ Physician/Clinic ❑ Family/friend ❑ Clergy ❑ Employer/Coworker ❑ 800-MD-SINAI ❑ Mount Sinai Website ❑ Insurance ❑ No Referring MD ❑Self ❑ **Other**:

❑ *Check if this is a* ***second opinion***

Referral Name:	
Referral E-mail:	
Referral Address:	
Referral Phone: ( )	**Referral Fax**: ( )

OTHER TREATING PHYSICIANS

Primary Care Physician:	
Address:	Phone: ( )
Fax: ( )	
Specialist Physician(s):	
Physician Name:	Address:
Phone: ( )	Fax: ( )
Physician Name:	Address:
Phone: ( )	Fax: ( )

INSURANCE INFORMATION					
(Please present your insurance card to the receptionist.)					
Person responsible for bill: ❑ Self		**Birth Date**: / /	**Address** (if different):		**Home Phone**: ( )
Occupation:	**Employer**:		**Employer Address**:		**Employer Phone**: ( )
Name of primary insurance:					
Subscriber's Name: ❑ Self			**Birth Date**:	**Group #**:	**Policy #**:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

SECONDARY INSURANCE (IF APPLICABLE)				
Name of secondary insurance:		**Subscriber's Name**:	**Group #**:	**Policy #**:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY		
Please notify in case of emergency:	**Relationship to Patient**:	
❑ Check if address is the *same* as in patient information		
Address:	**City, State**:	**Zip**:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the ***Department of Otolaryngology-Head & Neck Surgery*** and/or insurance company to release any information required to process my claims.

Patient/Guardian signature:		**Date**:
Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I,

Patient's last name:	**First**:
E-mail Address:	

, hereby consent to have my physician,

Physician name:

, communicate with me or members of his staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mails communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

Patient Name:	**Patient Signature**:
Today's Date:	**Appointment Date**:

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

MR-240 (9/03)

Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient/Legal Representative Signature: ____

DATE: ____________________

form version for eSignature

MT. SINAI DEPARTMENT OF OTOLARYNGOLOGY
REVIEW OF SYSTEMS

Patient Name: ______________________ **Date:** ____________

General/Constitutional	Yes	No
Change in appetite		
Fatigue		
Fever		
Sleep Disturbance		
Weight gain		
Weight loss		

Allergic / Immunology	Yes	No
Allergic rhinitis		
Hay fever		
Positive TB test		
Hives		
HIV (+)		
Food allergies		
Other:		

Ear / Nose / Mouth / Throat	Yes	No
Tinnitus		
Sinusitis		
Nasal polyps		
Altered sense of smell		
Nose bleeds		
Deviated septum		
Mouth sores		
Pain with chewing		
Facial trauma		
Dizziness/Vertigo		
Hearing Loss		
Ear discharge		
Ear pain		
Sore throat		

Do you drink alcohol?	Yes	No
How much?		

Endocrine	Yes	No
Thyroid lump / nodule		
Eye protrusion		
Diabetes w/insulin		
Diabetes w/o insulin		
Menstrual disorders		
Cold intolerance		
Excessive sweating		
Excessive thirst		
Frequent urination		
Heat intolerance		

Respiratory	Yes	No
Chest congestion		
Hoarseness		
Excessive throat clearing		
Spitting up blood		
Asthma		
Chronic Bronchitis		
Emphysema		
Tuberculosis		
Lung Cancer		
Cough		
Wheezing		

Cardiovascular	Yes	No
High Blood Pressure		
Swelling of the ankles		
Angioplasty		
Coronary artery stents		
Pacemaker		
Chest pain at rest		
Chest pain with exertion		
Palpitations		
Shortness of breath		

Do you smoke?	Yes	No
How much?		

Genitourinary	Yes	No
Abdominal pain/swelling		
Blood in urine		
Difficulty on Urination		
Frequent Urination		
Pain in lower back		
Painful urination		

Musculoskeletal	Yes	No
Back pain		
Arthritis		
Joint stiffness		
Muscle aches		
Painful joints		
Swollen joints		
Muscle weakness		

Skin	Yes	No
Sores/Growths		
Nail changes		
Itching		
Rash		

Neurological	Yes	No
Head injury		
Balance difficulty		
Gait abnormality		
Headache		
Memory loss, confusion		
Seizures		
Tingling/Numbness		
Tremor		

Height:

Weight:

All Medications and Dosages **(inc. non-prescription)** None ☐

All Surgeries / Operations None ☐

Past and Present Medical Problems

Family History of conditions related to your complaint:

Chief Complaint - Primary reason for today's visit:

Which Medications are you allergic to: None ☐

Patient Signature ______________________

Physician Signature ______________________ **Date** ____________

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Mount Sinai Doctors Faculty Practice (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website, can be provided to me upon request, and may be posted in the office.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though they may be employed by, contracted by, or affiliated with Mount Sinai Health System hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, are contracted by, or are affiliated with Mount Sinai Health System hospitals or facilities by visiting http://www.mountsinai.org/patient-care/find-a-doctor . I also understand that I can determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting those facilities' web portals at www.mountsinaihealth.org/insuranceinfo

I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services (even if those services are provided by Mount Sinai Health System facilities, laboratories, or providers). I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation.

I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

______________________________________ DATE: ________________

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

MOUNT SINAI HEALTH SYSTEM

NOTICE OF PRIVACY PRACTICES

Patient Name:

Date of Birth:

MRN:

I am aware of Mount Sinai Health System's Notice of Privacy Practices and I understand that if I would like a copy of the booklet. I can pick one up at the front desk.

Date: ____________________

Patient Signature: ______________________________________