Mount Sinai West

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 ❑ Undisclosed
Street Address/Apt:	**City**:	**State & Zip Code**:
Email address:	**Social Security:**	
Cell/Mobile phone: ( )	**Home Phone**: ( )	**Work Phone**: ( ) **Ext**:
Employer Name:	**Employer Address**:	**Occupation**:

PHARMACY INFORMATION

It is now New York State law that all prescriptions need to be sent to your pharmacy electronically. Please provide the information about your preferred pharmacy so that our doctors can make sure all your prescriptions are sent there in a timely manner.

Pharmacy Name:	**Pharmacy Address**:
Pharmacy Phone: ( )	**Pharmacy Fax**: ( )

HOW WERE YOU REFERRED TO THIS OFFICE?

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 ❑Zocdoc

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

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

TREATING PHYSICIAN

❑ **Same as above**

Name of your Primary Care Physician:

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:	

Physician name:

hereby consent to have my physician, 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:

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:

Mount Sinai Doctors

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. **Signature of Patient:**	**Date:**

MOUNT SINAI HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES, NO SHOW POLICY, AND IN-NETWORK DEDUCTIBLE

Patient Name:	**Date of Birth:**
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. The last pages included here are the Department of Otolaryngology Cancellation and No Show Policy and the Notice Regarding Potential In-Network Deductible Expenses. I acknowledge that I received both.	
Patient Signature:	**Date:**

MOUNT SINAI HEALTH INFORMATION EXCHANGE (HIE) AND HEALTHIX CONSENT FORM

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants is updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of "The Mount Sinai Health System" (defined in MS HIE Fact Sheet) to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE. PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. I can also change my decision at any time by completing a new form. You have the following choices below. Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of** my electronic health information through the **Mount Sinai HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access** my electronic health information through the **Mount Sinai HIE** or and **I DENY CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ANY of** my electronic health information through **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by applicable law.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

_____	_____
Print Name of Patient	Patient Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

MT. SINAI WEST 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		

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		

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		

Do you drink alcohol?	**Yes**	**No**
How much?		

Do you smoke?	**Yes**	**No**
How much?		

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** _____

Department of Otolaryngology – Head and Neck Surgery

The Mount Sinai Hospital
New York Eye and Ear Infirmary of Mount Sinai
Mount Sinai Beth Israel
Mount Sinai Queens
Mount Sinai Brooklyn
Mount Sinai West

NOTICE REGARDING POTENTIAL IN-NETWORK DEDUCTIBLE EXPENSES

Medical insurance issues can be very confusing and we are concerned about the impact payment policies may have on your medical expenses. We want you to be aware that a visit with one of our providers, even if the provider is considered in-network for your insurance, may still result in services from the visit being applied towards your 'in-network deductible'. An 'in-network deductible' is the amount of money considered by your carrier as the **patient responsibility** that must be satisfied by the patient before the carrier will make payment on your behalf.

In the Otolaryngology department, our providers start with a basic exam of your ears, nose and throat. When a provider needs more information, he or she may use an endoscope to help make an evaluation. This is a minimally invasive diagnostic medical procedure called an endoscopy. Additionally, a provider may perform an in-office procedure such as an injection, biopsy, comprehensive audiology or other necessary diagnostic services. Such services may be reported on your 'Explanation of Benefits' as Surgery simply because they are grouped with 'Surgery' description codes set forth by the American Medical Association (AMA).

Depending on the health care policy that you have chosen, any of the services, either mentioned above or not, may be applied towards your in-network deductible if it has not yet been satisfied. We will file the claim with your carrier first. **If there is a remaining balance as a result of not meeting your in-network deductible requirement, you will then be billed only the amount that the carrier 'approved' for payment – not the charged amount.**

We encourage you to contact your insurance provider, prior to your appointment, to better understand what your plan may or may not cover.

Thank you for trusting our physicians and staff with your care and for taking time to review the above information.

Department of Otolaryngology – Head and Neck Surgery
Mount Sinai Health System

Department of Otolaryngology – Head and Neck Surgery

The Mount Sinai Hospital
New York Eye and Ear Infirmary of Mount Sinai
Mount Sinai Beth Israel
Mount Sinai Queens
Mount Sinai Brooklyn
Mount Sinai West

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