| **PATIENT REGISTRATION** | **NEW YORK OTOLARYNGOLOGY GROUP** |
|---|---|

| **Patient Information:** | | |
|---|---|---|
| Last Name: | First Name: | Middle: |
| Date of Birth: | Gender *(circle one)*: Male Female Other | |
| Address: | | Apt. # |
| City: | State: | Zip: |
| Home Phone: | Work: | Cell: |
| Email address: | **Preferred Contact** *(circle one)*: Phone Call Text | Email |
| Do you need an Interpreter: Y N | Preferred Language: | |
| *Race *(circle one)*: American Indian / Asian / Black or African American / Caucasian / Other / Declined<br>*Ethnicity *(circle one)*: Hispanic / Non- Hispanic / Declined | | |
| Marital Status: | | |
| Emergency Contact Name: | Relationship: | |
| Emergency Contact Phone #: | | |

| **Physician Information:** | |
|---|---|
| Primary Care MD Name: | Phone #: |
| Referring MD Name: | Phone #: |
| Pharmacy Name: | Phone #: |

| **How Did You Find Us?** | | |
|---|---|---|
| Referring Physician ____ | Health Plan Directory____ | ZocDoc____ |
| Friend/Family ____ | Marketing/Internet____ | Website: _____ |
| Referral Center ____ | Other: _____ | |

| **Guarantor Information: (*Person to be billed, if different from patient*)** | | |
|---|---|---|
| Last Name: | First Name: | Middle: |
| Date of Birth: | Employer: | |
| Address: | | Apt. # |
| City: | State: | Zip: |
| Home Phone: | Work Phone: | Cell: |

**Please Provide Insurance Card(s) and Medical Records to Front Desk**

**The Centers for Medicare and Medicaid Services (CMS) require that we collect the following additional demographic information. Be assured that any information that WCPN collects related to race, ethnicity or language is used to provide care tailored to the needs of each patient*

**Patient Clinical Information:**

Last Name: First Name: Middle: Date of Birth:

**Reason for Visit:**

**Medications:** (List all that you are taking)

**Allergies:** (To Medications or Substances)

**Social History:**

**Do you smoke?** *(circle one)*: Y N **Did you smoke?** *(circle one)*: Y N **If Yes** *(circle one)*: Cigarettes Cigars Pipe

**If you ever smoked, when did you stop?** _____

**Do you drink?** *(circle one)*: Y N **If so, how many per day?** _____

**Do you ever or have you ever used IV drugs?** *(circle one)*: Y N

**Past or Current Medical Illnesses:** *check all that apply*

| | | | |
|---|---|---|---|
| Hypertension (High Blood Pressure) __ | Bleeding Disorder __ | Lung Disease (COPD, Asthma) __ | Environmental Allergies __ |
| Neurological Disorder __ | Heart Disease __ | Kidney Disease __ | Elevated Cholesterol __ |
| Arthritis __ | Glaucoma __ | Thyroid Disease __ | Stroke __ |
| HIV __ | Diabetes __ | | |

Do you have a Pacemaker ? *(circle one)*: Y N Any problems with hearing **?** *(circle one)*: Y N

**Hospitalizations / Surgeries:** **Reason for Hospitalization / Type of Surgery:**

Year: _____ Reason _____

Year: _____ Reason _____

**Family History:** Please *check if your relatives have had:*

| | | |
|---|---|---|
| Hypertension __ | Anemia __ | Cancer (type): |
| Stroke __ | Asthma __ | |
| Heart Disease __ | Autoimmune Disease __ | Other: |
| Diabetes __ | Hearing Loss __ | |

**Review of Systems: Do you experience any of the following?** *check all that apply*

| Constitutional | EYES | ENDOCRINE | ALLER/IMMUNO |
|---|---|---|---|
| Activity Change___ | Eye Discharge__ | Cold Intolerance___ | ENV Allergies__ |
| Appetite Change ___ | Eye Itching__ | Heat Intolerance____ | Food Allergies __ |
| Chills ___ | Eye Pain__ | Polydipsia (Excessive Thirst)____ | Immunocompromised (impaired immunesystem)__ |
| Diaphoresis (Sweating) ___ | Eye Redness__ | Polyphagia (Excessive Hunger)__ | NUEROLOGICAL |
| Fatigue___ | Photophobia (Sensitivity to Light)__ | Polyuria (Large Volume of Diluted Uri | Dizziness__ |
| Fever____ | Visual Disturbance__ | GENITOURINARY | Facial Asymetry__ |
| Unexpected Weight Change__ | RESPIRATORY | Difficulty Urinating__ | Headaches__ |
| HENT | Apnea (Breathing Stops)__ | Dysuria (Painful Urination)__ | Light-Headedness__ |
| Congestion___ | Chest Tightness___ | Enuresis (involuntary Urination)__ | Numbness__ |
| Dental Problem___ | Choking__ | Flank Pain__ | Seizures__ |
| Drooling___ | Shortness of Breath__ | Frequency__ | Speech Difficulty__ |
| Ear Discharge__ | Stridor (Noisy Breathing)___ | Genital Sore__ | Syncope (temporary loss of consciousness)__ |
| Ear Pain__ | Wheezing__ | Hemturia (Bloody Urine) | Tremors__ |
| Facial Swelling ___ | CARDIOVASCULAR | Penile Discharge__ | Light-Headedness__ |
| Hearing Loss__ | Chest Pain___ | Penile Pain__ | Weakness___ |
| Mouth Sores ___ | Leg Swelling__ | Penile Swelling__ | HEMATOLOGIC |
| Nosebleeds___ | Palpatations__ | Scrotal Swelling__ | Adenopathy ( Swollen Lymph Nodes)__ |
| Postnasal Drip___ | GASTROINTESTINAL | Testicular Pain__ | Bruise/Bleed Easily__ |
| Rhinorrhea (Runny Nose)___ | Abdominal distension___ | Urgency__ | PSYCHIATRIC |
| Sinus Pressure___ | Abdominal Pain__ | Urine Decreased__ | Agitation__ |
| Sneezing___ | Anal Bleeding__ | MUSCULOSKELETAL | Behavior Problem__ |
| Sore Throat___ | Blood in Stool_ | Arthralgias | Confusion__ |
| Tinnitus___ | Constipation__ | Back Pain__ | Decr Concentration__ |
| Trouble Swallowing___ | Diarrhea__ | Gait Problem (Arthritis of the Leg)__ | Dysphoric Mood(Depression/Anxiety)__ |
| Voice Change___ | Nausea__ | Joint Swelling/Pain__ | Hallucinations__ |
| | Rectal Pain__ | Myalgias (Muscle Aches)__ | Hyperactive___ |
| | Vomiting__ | Neck Pain___ | Nervous/Anxious__ |
| | | SKIN | Self-Injury___ |
| | | Color Change___ | Sleep Disturbance___ |
| | | Pallor (Pale Appearance)___ | Suicidal Ideas___ |
| | | Rash__ | |
| | | Wound___ | |

Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

# Financial Policy

*Welcome to the Department of Otolaryngology-Head & Neck Surgery. The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.*

**Financial Policy**

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the physician you are seeing.

**Participating Plans**

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

**Non-Participating Plans**

In this scenario the physician you will see does not participate in your insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

**Medicare**

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

**Usual and Customary Rates**

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Payment**

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

*We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office*.

X_____ _____

Signature of the patient or responsible party Date

Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

# PAYMENT POLICY FOR ADULT IN-OFFICE PROCEDURES

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation and treatment of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

**Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**

**Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**

**Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**

**Laryngeal Stroboscopy: Examination of the larynx and vocal cords under stroboscopic light.**

**Cerumen removal: Removal of wax from the ear canals.**

**In Addition:**

**Audiometric Evaluation: Tests the ability to hear pure tones, tests bone conduction and air conduction, may require an additional copay, depending on insurance carrier.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name (Print) _____

X_____ _____

Signature of the patient or responsible party Date