Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

Anthony Sclafani, MD

Patient Name:			DOB:		
Have You Ever Had:	YES	NO	Are you being seen for a cosmetic consultation:		
High Blood Pressure?	☐	☐	Complete this section ONLY if answer is YES	YES	NO
Irregular Heartbeat/Pacemaker?	☐	☐	Do you plan to gain or lose more than 10 lbs?	☐	☐
Heart Disease/Angina/Mitral Valve Prolapse?	☐	☐	Current wt_____; Weight 1 year ago_____	☐	☐
Kidney Disorders?	☐	☐	Do you exercise regularly?	☐	☐
Lung or Respiratory Disease?	☐	☐	How long have you been thinking about having plastic surgery?		
Tuberculosis (TB)?	☐	☐			
Asthma?	☐	☐			
Arthritis/Joint Disease?	☐	☐	Have you had plastic surgery before?	☐	☐
Hepatitis/Liver Disease?	☐	☐	If YES, what was done? When?		
Stomach Trouble (including Ulcers)?	☐	☐	Were you happy with the results?	☐	☐
Thyroid Dysfunction?	☐	☐	Eye disease, including glaucoma or "dry eyes"?	☐	☐
Anemia/Blood Disorder?	☐	☐			
AIDS/HIV+?	☐	☐	Have you ever had any other surgery to your head, face or neck?	☐	☐
Depression/Anxiety/Panic Attacks?	☐	☐			
Are you currently under psychiatric care?	☐	☐	How do you think plastic surgery will benefit you?		
Ever had an injury to your head, face or neck?	☐	☐			
Cancer (including skin cancer)? Site:	☐	☐	Do you think plastic surgery will significantly change your life?	☐	☐
Ever had Chemotherapy or Radiation?	☐	☐			
Do you Smoke? How Much?	☐	☐	If YES, in what way?		
Drink Alcohol? How much?	☐	☐	Which of the following are you interested in improving?		
Require treatment for Hay Fever or other Allergies?	☐	☐	☐ Nose		
			☐ Breathing	☐ Appearance	
Difficulty Breathing through your nose? Shortness of breath?	☐	☐	☐ Chin	☐Hair	
			☐ Eyelids	☐Ears	
Frequent Nosebleeds? Bruise easily	☐	☐	☐Scars		
Any skin disease? (cold sores, herpes, eczema, psoriasis, acne, fever blisters, dermatitis?	☐	☐	☐ Acne	☐ Other	
			☐ Forehead/Brow	☐ Wrinkles	
Allergic to adhesive tape, iodine or any cosmetics?	☐	☐	☐ Face (Facelift)	☐ Facial blemish (i.e.mole)	
			☐ Cheek, Lips	☐ Other	
Ever received local anesthesia from doctor/dentist?	☐	☐	Please list all your current medications, including dose. *(remember to include aspirin, Advil, birth control pills and hormones, steroids, heart and asthma medications, blood thinners, antidepressants and vitamins.)*		
Have an adverse reaction?	☐	☐			
WOMEN: Do you suspect you might be pregnant?	☐	☐			
Last menstrual period:	☐	☐			
Please explain any YES answers:					
			Describe allergic reactions to medications you may have had:		
List any other medical problems/serious illness you may have:			☐ Penicillin	☐ Amoxicillin/Augmentin	
			☐ Erythromycin	☐ Cipro	
List all prior surgery:			☐ Sulfa drugs	☐ Local Anesthetic	
			☐ Aspirin	☐ Codeine	
X			☐ Other		
Patient Signature	Date		☐ To my knowledge, I have NEVER had an allergic reaction to any medications both prescribed and over the counter.		

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

Anthony Sclafani, MD

Date:	Office:	Primary Language Spoken:	
Name:			
Sex: ☐ M ☐ F	Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced		
Race:	Ethnicity:	Advanced Directives: ☐ YES ☐ NO	
DOB:	Social Security#:		
Responsible Party:		Relationship:	Phone:
Patient Address:			
Permanent Address (If different):			
Home Telephone:		Cell:	
Email:			
Employed by:		Occupation:	
Business Address:			Phone:
Emergency Contact:		Relationship:	Phone:
Allergies to Medications:			
Referred By:		Reason for Visit:	
Check one: Illness/ Injury Related to: ☐ Work ☐ Auto ☐ Other			Date of Incident:
INSURANCE INFORMATION			
Primary Insurance Company:			☐ HMO ☐ PPO ☐ POS
Policy/ID#		Group #	
Policy Holder:		Relationship:	
Policy Holder DOB:		Social Security#:	
SECONDARY Insurance Company:			☐ HMO ☐ PPO ☐ POS
Policy/ID#		Group #	
Policy Holder:		Relationship:	
Policy Holder DOB:		Social Security#:	

Weill Cornell Medicine
Otolaryngology
Head & Neck Surgery

Anthony Sclafani, MD

NASAL FUNCTION QUESTIONNAIRE

Please check the appropriate box for the following five questions related to your breathing.

	Not a Problem (0)	Very Mild Problem (1)	Moderate Problem (2)	Fairly Bad Problem (3)	Severe Problem (4)
Nasal Congestion or Stuffiness					
Nasal Blockage or Obstruction					
Trouble Breathing Through My Nose					
Trouble Sleeping					
Unable to Get Enough Air Through My Nose During Exercise or Exertion					

Raw

Final

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

COSMETIC CONSULTATION FORM

The cosmetic consultation fee is $250, payable on the day of your visit. For surgical procedures performed in an operating room facility, the cosmetic consultation fee will be applied to the cost of the procedure. This does not apply to office procedures.

AUTHORIZATION: I authorize treatment of the individual named as patient. I understand that Dr. Sclafani or his agents will file with my primary insurance for services rendered and I authorize payment of medical insurance benefits to be made directly to my treating physician, Anthony P. Sclafani, MD. I also understand that I am financially responsible for any service that is not covered under the terms of my insurance policy. I understand that for any procedure(s) deemed a. medically necessary, b. cosmetic, or c. not covered under the terms of my policy, I am will be financially responsible for payment in full and will be billed accordingly.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing.

I authorize Dr. Sclafani or his agents to release or obtain any medical information related to the treatment of the patient. A photocopy of this authorization shall be considered as effective and valid as the original. I agree that all photocopies of this form may be used in lieu of the original. I fully understand and agree to comply with this policy.

Patient Name: _____

(Print)

Signature: _____ **Date:** _____

(Patient or Responsible Party)

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

REFERRING PHYSICIAN, MEDICATION AND PHARMACY INFORMATION FORM

Patient's Name:	**Date:**
Name and Address of Internist or Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	**Fax:**

MEDICATIONS

Do you have any allergies to medications? ☐ No ☐ Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

MEDICATIONS	DOSAGE (mg, teaspoon, etc)	FREQUENCY

VACCINATION HISTORY

Date of most recent Flu Shot (ages 6 mos +) Date of most recent Pneumonia Shot (ages 65+)

PHARMACY INFORMATION

In order to expedite prescription service, if required, we would like to have your pharmacy information on file

Pharmacy Name:	
Address	
Telephone:	**Fax:**
Patient's Signature:	

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

OTOLARYNGOLOGY (ENT)

PAYMENT POLICY FOR 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.**

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)

Signature: _____ **Date:** _____

(Patient or Responsible Party)

Weill Cornell Medicine

Department of Otolaryngology –
Head and 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.

Signature of Patient or Responsible Party **Date**

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

Anthony Sclafani, MD

CONSENT FOR PHOTOGRAPHY

I, the undersigned, _____, am a patient of Anthony P. Sclafani, MD and consent to be photographed (film and digital media- still photographs and video) as relates to my treatment. This may be performed before, during or after treatment, in either the physician's office or operating room.

I understand that Dr. Sclafani, where applicable, may frequently obtain before and after clinical photographs. While these photographs are primarily used to improve and optimize the communication between you and Dr. Sclafani, he may occasionally also depend on the ability to share this clinical photographic information with your referring physician(s), insurance companies and others. Furthermore, such information is vitally needed to increased and advance medical education and research.

In the course of consultation and discussions with Dr. Sclafani and his staff, I may be shown or provided certain brochures, pictures of actual patients or pictures of myself on an electronic imaging device. I do understand that those pictures and alterations of these pictures seen are solely for the purpose of illustration, discussion and to provide improved communications with medical professionals. I do understand that the outcome of any type of surgical procedure is directly related to my individual characteristics and health. I further understand and acknowledge that because of the obvious significant differences in how living tissues react to surgery, there may be no relationship between the electronic images created, and my actual final surgical result. Use of the computer imaging system offers an opportunity for me to discuss my desires and to allow improved communication with the medical staff.

I certify my understanding that there is NO WARRANTY, expressed or suggested, as to my own final appearance after elective surgery by the use of these electronically altered images.

The undersigned grants to Dr. Sclafani the on-going and unrestricted use of the undersigned's photographs and altered electronic images for general information, education, scientific and medical purposes at any time during or after treatment, with complete confidentiality of the my identity.

The undersigned further acknowledges that he/she relinquishes all right, title, and interest in these photographs, or any right to profit or gain directly or indirectly realized through the use of these photographs. I release Dr. Sclafani, his agents, employees, licensees and assigns from any and all claims I may have now or in the future for invasion of privacy, right of publicity, copyright infringement, defamation or any other cause of action arising out of the use, reproduction, adaptation, display or transmission of this material. I waive any right to inspect or approve any works that may contain these materials. The persons to whom disclosure may be made include physicians, medical students, patients and prospective patients, examining boards, medical or other periodicals, medical editors, insurers (if any), outside firms, the staff of the American

Academy of Facial Plastic & Reconstructive Surgery (AAFPRS) and the AAFPRS Foundation or other academic/scientific organization, readers of medical literature and the general public.

This consent may only be revoked in writing, signed by the undersigned and delivered to Dr. Sclafani at his office. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Sclafani. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial plastic surgery, except there will be no expiration for the purpose of medical or scientific research. Revocation will not affect uses and disclosures made before receipt of the revocation. If the photographs are disclosed, there is obvious potential for redisclosure some of which would not be subject to this authorization. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by Dr. Sclafani, and there have been no representations or inducements concerning this consent except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization, but if any portion of the treating physician's services is to be covered under any insurance or third-party payment plan, the signing individual will be responsible for authorizing release as required by that insurance or third-party payment plan.

I provide this authorization as a voluntary contribution in the interests of public education.

Patient Name: _____

Signature: _____ **Date:** _____

(Patient or Responsible Party)