Weill Cornell Medicine

NEW PATIENT FORM

David J. Phillips, M.D.

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:		**Date of Visit:**
Date of Birth:	**Email**:	**Preferred Phone:**

Referring MD:	**Primary Care MD:** ❑ Same	**Pharmacy Preference:**
Name:	Name:	Name:
Phone Number:	Phone Number:	Phone Number:
Address:	Address:	Address/Cross streets:

How did you hear about our practice?

❒ Referring/Primary MD ❒ Call Center ❒ Website ❒ Social Media ❒ Friend/Patient of Practice: _____

Reason For Visit:	**Occupation:**	**Employer:**

Medications (Name, dosage) *(Remember to include aspirin, Advil, birth control pills and hormones, steroids, blood thinners, vitamins and supplements.)*	**Do you have problems in any of the following areas?**		
	Fevers/Chills/Weight:	□ No	□ Yes
	Eyes:	□ No	□ Yes
	Ear, Nose, Mouth, Throat:	□ No	□ Yes
	Cardiovascular:	□ No	□ Yes
	Respiratory:	□ No	□ Yes
	Gastrointestinal:	□ No	□ Yes
	Musculoskeletal:	□ No	□ Yes
	Genitourinary:	□ No	□ Yes
Allergies	Skin:	□ No	□ Yes
(Medication, Food, Environmental, Etc. Please include what the reaction you had)	Neurological:	□ No	□ Yes
	Endocrine:	□ No	□ Yes
	Blood/Lymphatic:	□ No	□ Yes
	Immunologic:	□ No	□ Yes
	Psychiatric:	□ No	□ Yes

What other Medical Problems do you have?	Do you smoke? Did you quit? When?	Do you drink? How many per week?

What Surgeries (including cosmetic procedures) have you had? Include procedure, approximate date, location, and surgeon.

Weill Cornell Medicine

NEW PATIENT FORM

David J. Phillips, M.D.

Please Note: All information is confidential and will become part of your medical record
PLEASE PRINT CLEARLY

Patient Name:	Date of Visit:
Are you being seen for a cosmetic consultation? ❒ YES ❒ NO	

Complete this section ONLY if being seen for a cosmetic consultation:

Have You Ever Had:	YES	NO
Eye disease, including glaucoma or dry eyes?	❒	❒
Thyroid dysfunction?	❒	❒
Sleep apnea?	❒	❒
Do you snore?	❒	❒
Depression, anxiety, or panic attacks?	❒	❒
Asthma?	❒	❒
Easy bruising?	❒	❒
Bleed easily?	❒	❒
Difficulty breathing through your nose?	❒	❒
Frequent nosebleeds?	❒	❒
Cold sores?	❒	❒
Eczema, psoriasis, or acne?	❒	❒
Ever had chemotherapy or radiation?	❒	❒
Ever had skin cancer? Site:	❒	❒
Ever received local anesthesia?	❒	❒
Have an adverse reaction to local anesthesia?	❒	❒
Injury to face, head or neck?	❒	❒
Allergy to adhesive tape, iodine, or cosmetic?	❒	❒

Any additional information on Yes answers below:

Which of the following are you interested in improving?

❒ Nose: ❒ Breathing ❒ Appearance
❒ Face/Neck
❒ Eyes
❒ Forehead/Brow
❒ Wrinkles
❒ Facial blemish (i.e. mole)
❒ Lips
❒ Chin
❒ Cheek
❒ Ears
❒ Scars
❒ Other:

Have you ever had Botox/Dysport/Xeomin? ❒ YES ❒ NO

Have you ever had facial fillers? ❒ YES ❒ NO
If yes, type of filler and location(s) on face:

The information is accurate and complete to the best of my knowledge.
I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Signature:	Date:

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

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

David J. Phillips, M.D.
Facial Plastic and Reconstructive Surgery

COSMETIC CONSULTATION FORM

The cosmetic consultation fee is 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 in-office injections.

AUTHORIZATION: I authorize treatment of the individual named as patient. I understand that Dr. Phillips 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, David J. Phillips, M.D. 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. Phillips 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
Otolaryngology
Head & Neck Surgery

David Phillips, M.D.

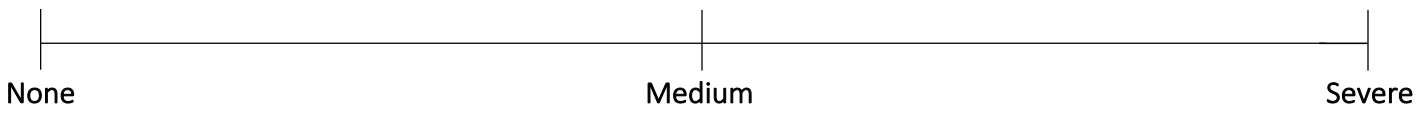
NASAL FUNCTION QUESTIONNAIRE

To Our Patients: Please help us understand the impact of nasal obstruction on your quality of life by completing the following questionnaire.

Over the past 1 month, how much of a problem were the following conditions to you?

	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					

Please mark on this line how troublesome is your difficulty in breathing through your nose:



Weill Cornell Medicine

David J. Phillips, M.D.
Facial Plastic and Reconstructive Surgery

CONSENT FOR PHOTOGRAPHY

I, the undersigned, _____, am a patient of David J. Phillips, M.D., and consent to be photographed in relation to my treatment. This may be performed before, during or after treatment, in either the physician's office or operating room.

These photos are primarily used to improve and optimize communication between you and Dr. Phillips. Occasionally, Dr. Phillips depends on the ability to share the clinical photographic information with your referring physician(s), insurance company, or medical colleagues. I therefore grant to Dr. Phillips the on-going and unrestricted use of these photographs and any simulation images, with complete confidentiality of my identity, for the purposes of medical communication, education (ie. lectures to medical colleagues), or scientific research (ie. in medical journals/textbooks).

I understand that my photographs will not be used for marketing purposes (website, social media, pamphlets, etc.) or shown to other prospective patients in office unless Dr. Phillips personally requests this of me at a later date and I sign a separate consent for marketing purposes.

I acknowledge that I relinquish all right, title, and interest in these photographs or any right to profit or gain directly or indirectly through the use of these photographs. I release Dr. Phillips and any designated agents from any 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 from the use, reproduction, display, or transmission of this material. I waive the right to inspect or approve any works that may contain these materials. The persons to whom disclosure may be made include physicians, medical trainees, examining boards, periodicals, members of scientific/academic organizations, insurers, and readers of the medical literature.

This consent may be revoked in writing, signed by the undersigned, and delivered to Dr. Phillips. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial plastic surgery. There will be no expiration for the purposes of medical or scientific research.

I understand that my treatment by Dr. Phillips is not contingent upon or a condition of signing this authorization. However, if any portion of the physician's services is to be covered under 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.

Patient Name: _____

(Print)

Signature: _____ **Date:** _____

Weill Cornell Medicine

David J. Phillips, M.D.
Facial Plastic and Reconstructive Surgery

(Patient or Responsible Party)