Weill Cornell Medicine

Victoria Banuchi-Crespo, MD

| | | | | |
|---|---|---|---|---|
| Patient's Name: | | | | Date: |
| Date of Birth: | Age: | Weight: | Height: | |
| Reason for Visit: | | | | |
| Occupation/Employer: | | | | |
| Marital Status: | Name of Spouse/Significant Other: | | | |
| Children's Names & Date of Birth (if applicable): | | | | |

| Please list all prior major illness/surgeries (with years): | | | |
|---|---|---|---|
| Operations: | 1. | 2. | 3. |
| Hospitalizations: | 1. | 2. | 3. |
| Illness/Injuries: | 1. | 2. | 3. |

| | | | | | |
|---|---|---|---|---|---|
| Family History (check) | ❒ Heart Disease | ❒ Diabetes | ❒ Cancer | ❒ Other: | |
| Which Family Member? | | | | | |
| Do you drink alcohol? | ❒ No, Never | ❒ No, but I used to | ❒ Yes | How many? | Day/Week |
| Do you smoke? | ❒ No, Never | ❒ No, I quit in | ❒ Yes | Packs per day? | x Years |
| Do you use illicit drugs? | ❒ No, Never | ❒ No, but I used to | ❒ Yes | Which drug? | |

| Have you experienced any of the following? | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **CONSTITUTIONAL** | | | **CARDIOVASCULAR** | | | **GENITOURINARY** | | |
| Weight Gain/Loss (>15 lbs) | ❒ Y | ❒ N | Heart Attack | ❒ Y | ❒ N | Frequent Urination | ❒ Y | ❒ N |
| Constant Night Sweats | ❒ Y | ❒ N | High Blood Pressure | ❒ Y | ❒ N | Prostate Problems | ❒ Y | ❒ N |
| **EYES** | | | Heart Murmur | ❒ Y | ❒ N | **SKIN** | | |
| Double Vision | ❒ Y | ❒ N | **GASTROINTESTINAL** | | | Past Skin Cancer | ❒ Y | ❒ N |
| Glaucoma | ❒ Y | ❒ N | Chronic Diarrhea | ❒ Y | ❒ N | Past Radiation Therapy | ❒ Y | ❒ N |
| **EAR/NOSE/THROAT** | | | Heartburn | ❒ Y | ❒ N | **MUSCULOSKELETAL** | ❒ Y | ❒ N |
| Hearing Loss | ❒ Y | ❒ N | **ENDOCRINE** | | | Arthritis | ❒ Y | ❒ N |
| Ear Pain | ❒ Y | ❒ N | Diabetes | ❒ Y | ❒ N | Chronic Back Pain | ❒ Y | ❒ N |
| Ringing in Ears | ❒ Y | ❒ N | Thyroid Disease | ❒ Y | ❒ N | **RESPIRATORY** | | |
| Balance Problems | ❒ Y | ❒ N | Autoimmune Disease | ❒ Y | ❒ N | Asthma/Emphysema | ❒ Y | ❒ N |
| Hearing Aid | ❒ Y | ❒ N | **NEUROLOGIC** | | | Chronic Cough | ❒ Y | ❒ N |
| Difficulty Breathing | ❒ Y | ❒ N | Headaches | ❒ Y | ❒ N | Tuberculosis | ❒ Y | ❒ N |
| Nosebleeds | ❒ Y | ❒ N | Seizures | ❒ Y | ❒ N | **PSYCHIATRIC** | | |
| Nasal Drainage | ❒ Y | ❒ N | Stroke | ❒ Y | ❒ N | Anxiety | ❒ Y | ❒ N |
| Sinus Problems | ❒ Y | ❒ N | **HEMATOLOGY** | | | Depression | ❒ Y | ❒ N |
| Snoring | ❒ Y | ❒ N | Bruise Easily | ❒ Y | ❒ N | Sleep Apnea | ❒ Y | ❒ N |
| Voice Changes | ❒ Y | ❒ N | Anemia | ❒ Y | ❒ N | | | |

If you answered YES to any of the above, please explain:

**Reviewed by:** Victoria Banuchi-Crespo, MD

# 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

# Authorization To Use or Disclose Protected Health Information (PHI)

Patient Name: _____ MRN#: _____

Street: _____ DOB: _____

City: _____ Phone: _____

ST: _____ Zip: _____ NYP#: _____
(if available)

I authorize the release of the following health information:

- ☐ Entire medical record
- ☐ Diagnostic Tests Date(s): _____
- ☐ Doctor's Notes (from Dr. _____) Date(s): _____
- ☐ Lab Results Date(s): _____
- ☐ Pathology Reports ____ Specimens ____ Date(s): _____
- ☐ Radiology Reports ____ Images ____ Date(s): _____
- ☐ Include Alcohol/Drug Treatment information (initial here) _____
- ☐ Include Mental Health information (initial here) _____
- ☐ Include HIV-Related information (initial here) _____
- ☐ Medical Record/Information from outside the institution brought to the practice by me (explain):
  _____
- ☐ All of the above with the exception of: _____
- ☐ Other: _____

**Who will <u>release/disclose</u> information**: Name: _____
Address: _____
City, State, Zip: _____

**Who will <u>receive</u> information**: Name: _____
Address: _____
City, State, Zip: _____

Reason for Disclosure: _____

This authorization expires: ☐ specific time frame _____, ☐ when record is received, ☐ other (explain)

I understand that:

- By signing this form, I am authorizing the use/disclosure of protected health information as indicated above.
- I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization at any time by completing a "Request to Revoke an Authorization" form, which is available at Weill Cornell Medicine's Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
- If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. Weill Cornell Medicine shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatry notes, state or federal regulations may have additional compliance requirements.
- I may request a copy of this signed form.
- Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor's office will inform me of any charges and arrange for payment.

_____ _____
Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____
Print name Relationship to patient