Mount Sinai Doctors

Department of Otolaryngology-Head & Neck Surgery

We appreciate your cooperation in completing this form.
Once this form is complete, please fax it to 212-523-8168 or print it and bring it with you to your appointment.

Physician you are seeing:	**Appointment date**:

PATIENT INFORMATION

Last name:	**First**:	**Middle Initial**:	**Date of Birth :**

How did you hear of us?

(Please check all that apply): [ ] Friend /Relative [ ] Employer/Coworker [ ] Brochure [ ] City MD [ ] Email [ ] ENT [ ] Facebook/twitter/Instagram [ ]Google/Bing/Website [ ]Radio [ ]Health fair [ ] Insurance Co. [ ] Mount Sinai Website [ ]Newspaper [ ]Postcard [ ] Radio [ ]Subway/Bus/Kiosk Ad [ ] Television [ ] Walked By [ ] **Other**

Referring Physician: _____ **Tel.** _____

PRIMARY CARE PROVIDER INFORMATION

Name:		
Address:	**City, State**:	**Zip**:
Phone: ( )	**Fax :** ( )	

IN CASE OF EMERGENCY

Please notify in case of emergency Name:	**Relationship to Patient**:	
❑ Check if address is the same as the patient's		
Address:	**City, State**:	**Zip**:
Home Phone: ( )	**Work Phone:** ( )	**Cell Phone:** ( )

NYS LAW, ALL PRESCRIPTIONS MUST BE SENT ELECTRONICALLY TO YOUR PHARMACY PLEASE PROVIDE THE PHARMACY'S CONTACT INFORMATION:

PHARMACY INFORMATION

Pharmacy Name:		
Address:	**City, State**:	**Zip**:
Phone: ( )	**Fax :** ( )	

I acknowledge that I received the Department of Otolaryngology Cancellation and No Show Policy and the Notice Regarding Potential In-Network Deductible Expenses (found in this packet):

Signature: _____ **Date:** _____

MOUNT SINAI 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		
Do you drink alcohol?	**Yes**	**No**

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		
Do you smoke?	**Yes**	**No**

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		
Height: **Weight:**		

All Medications and Dosages **(inc. non-prescription)** None ☐

_____

_____

_____

_____

_____

All Surgeries / Operations None ☐

_____

_____

_____

_____

_____

Past and Present Medical Problems

_____

_____

_____

_____

_____

Are you, or could you be, pregnant? **Yes** | **No**

Chief Complaint - Primary reason for today's visit:

_____

_____

_____

Allergies: Medication/Other

_____

_____

_____

_____

Patient Signature _____

Mount Sinai Doctors

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I,

Patient's last name:	**First**:
E-mail Address:	

, hereby consent to have my physician,

Physician name:

, 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:

MR-240 (9/03)

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 425 W 59th St. Otolaryngology (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

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.	
Patient Signature:	**Date:**

MOUNT SINAI ENTERPRISE INFORMATION EXCHANGE CONSENT FORM

In this consent form, you can choose whether to allow Mount Sinai Health System (MSHS) to share your medical records with your non-Mount Sinai healthcare providers and to allow MSHS to access information about care provided to you by non-Mount Sinai providers through four health information technology platforms: the Mount Sinai Health Information Exchange ("Mount Sinai HIE"), Epic Care Everywhere, Carequality, and Healthix. These platforms can help collect the medical records you have in different places where you receive healthcare services and make them available electronically and securely to the providers treating you, thereby improving the quality of your healthcare services. To learn more about this kind of sharing in New York State, ask your provider for the "Better Information Means Better Care" brochure or find it under Resources on the ehealth4ny.org website. Upon request, your provider will print the participating provider/information sources lists for you from the websites mentioned below.

(**1**) **Mount Sinai HIE:** Give or deny consent to allow the participants (their employees, agents or members of their medical staff) listed on the Mount Sinai HIE website mountsinaiconnect.org ("HIE Participants") to access your electronic health information maintained in the Mount Sinai HIE, including records from your other healthcare providers authorized to disclose information through the Mount Sinai HIE.

(**2**) **Epic Care Everywhere** and (**3**) **Carequality**: Give or deny consent to allow the healthcare providers, their employees, agents or members of their medical staff, listed on the Epic website at epic.com/careeverywhere and the Carequality website at carequality.org/active-sites-search to access your health information maintained in the MSHS electronic medical record systems. **Regardless of your choice on this form, a provider at another participating organization may still ask for your authorization at the point of care to access information in your Mount Sinai electronic medical record.**

(**4**) **Healthix**: Healthix is a Health Information Exchange or Qualified Entity (QE), a not-for-profit organization certified and regulated by the New York State Department of Health to collect and aggregate information about medical services you received. Give or deny consent to allow MSHS (our employees, agents or members of our medical staff) to see and obtain access to your electronic health records from your other healthcare providers authorized to disclose information through Healthix. A list of the current authorized providers can be obtained on the Healthix website at healthix.org or by calling Healthix at 877-695-4749. You can deny consent to ALL provider organizations and health plans participating in Healthix to access your electronic health information available through Healthix at the same website or phone number.

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.

(continued on next page)

Your consent choice on this form will apply jointly to all four platforms. You may change your decision at any time in the future by completing a new form. **Please completely fill in only one choice out of the following 4 options**:

◯ **I GIVE CONSENT** to all of the Participants listed on the Mount Sinai HIE website to access my health information stored in the Mount Sinai HIE, to all of the Participants listed on the Epic and Carequality websites to access all of my MSHS electronic medical records, and to all employees, agents and members of the medical staff of MSHS to access all of my electronic health information available through Healthix in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services and emergency care.

◯ **I DENY CONSENT, EXCEPT IN A MEDICAL EMERGENCY**, to all of the providers listed on the Epic and Carequality websites to access my Mount Sinai electronic medical records. I also deny consent to all the Participants listed on the Mount Sinai HIE website to access my health information stored in the Mount Sinai HIE, except for information they provided themselves, and to all employees, agents and members of the medical staff of MSHS to access any of my electronic health information available through Healthix contributed by a non-Mount Sinai participant, except in a medical emergency.

◯ **I DENY CONSENT, EVEN IN A MEDICAL EMERGENCY**, to the Participants listed on the Mount Sinai HIE website to access my electronic health information stored in the Mount Sinai HIE, except for information they provided themselves, and to all employees, agents and members of the medical staff of MSHS to access any of my electronic health information available through Healthix contributed by a non-Mount Sinai participant for any purpose. I also deny consent to the Participants listed on the Epic and Carequality websites to access my MSHS electronic medical record, but **I understand that the Epic Care Everywhere and Carequality Participants may still access my information in an emergency as allowed by applicable law.**

◯ **I DO NOT WISH TO MAKE A DECISION AT THIS TIME**. I understand that Epic Care Everywhere and Carequality participants may be able to access information in my MSHS electronic medical record in a medical emergency as allowed by applicable law. MSHS providers may be able to access my information via Healthix in an emergency as allowed by applicable law.

My questions about this form have been answered and I have been given the choice to receive a copy of this form.

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

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

Cancellation and No Show Policy

Thank you for choosing our practice to address your Otolaryngology needs. We are committed to providing all of our patients with exceptional and timely care. With that said, we do understand that situations occur and it may become necessary for you to cancel your appointment. If you must cancel, we request that you **please provide notification at least two (2) business days in advance**. Your prompt notice of cancellation will allow another patient, who would otherwise be delayed in receiving medical care, access to an appointment. When cancellations are made less than two (2) business days in advance, we are unable to offer the slot to another patient.

Patients who cancel three (3) scheduled appointments, who miss three (3) appointments without notice (No Show), or those with a combination of the two, may be **discharged from The Department of Otolaryngology and denied future appointments**.

We thank your cooperation and attention to this policy.