

ENT FACULTY PRACTICE, LLP
ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize and direct my insurance carrier to make payment directly to ENT Faculty Practice, LLP and hereby assign to said office and any and all rights, title and interest I have in insurance proceeds or benefits payable to me or on my behalf for services rendered to me by said medical office.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE NAMED MEDICAL OFFICE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR ON MY BEHALF.

I hereby authorize and direct the above named medical office and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance and other payers.

Date

Time

Signature of patient/responsible person

Witness

IF PERSONS OTHER THAN THE PATIENT SIGNS, INDICATE RELATIONSHIP TO THE PATIENT AND REASON FOR LACK OF PATIENTS SIGNATURE.

PATIENT HIPPA AWARENESS

With my permission, ENT Faculty Practice, LLP may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please refer to ENT Faculty Practice, LLP Notice of Privacy Practices for more complete description of such uses and disclosures.

It is my responsibility to review the Notice of Privacy Practices prior to signing this consent. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of ENT Faculty Practice, LLP, may call my home or other designated locations and leave a message on my voice mail or in person in reference to any item that assists the practice in carrying out TPO , such as appointments, reminder cards, and patient statements. I have the right to request the ENT Faculty Practice, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does it is bound to this agreement.

By signing this, I am allowing ENT Faculty Practice, LLP to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

SIGNATURE OF PATIENT,
PARENT OR LEGAL GUARDIAN

PRINT NAME OF PATIENT
PARENT OR LEGAL GUARDIAN

PATIENT'S NAME: _____

DATE: _____

Department of Otolaryngology
New York Medical College
Maria Fareri Children's Hospital
Westchester Medical Center

ENT FACULTY PRACTICE

1055 SAW MILL RIVER ROAD
SUITE 101
Ardsley, NY 10502
Telephone: (914) 693-7636
Fax: (914) 693-5994
www.entfaculty.com



Augustine L. Moscatello, M.D., F.A.C.S.
David M. Merer, M.D., F.A.C.S., F.A.A.P.
Angela Damiano, M.D., F.A.C.S.
Craig H. Zalvan, M.D., F.A.C.S.
Katrina R. Stidham, M.D.
Lianne M. de Serres, M.D., M.S.
Steven A. Hemmerdinger, M.D.
Manoj T. Abraham, M.D., F.A.C.S.
Christine A. Fusillo, M.D., F.A.A.A.A.I.
Randi Sherman, Ph.D., CCC-A
Pam P. Greenspan, AuD., F.A.A.A.
Melanie Katz, AuD., F.A.A.A.
Amanda Muldoon, MS, CCC-A
Suzanne Lasseter, P.T.

GENERAL OTOLARYNGOLOGY
PEDIATRIC OTOLARYNGOLOGY
HEAD & NECK SURGERY
LARYNGOLOGY
RHINOLOGY
NEUROLOGY/OTOLOGY
FACIAL PLASTICS &
RECONSTRUCTION
ALLERGY & IMMUNOLOGY
AUDIOLOGY
BALANCE TESTING
VESTIBULAR THERAPY

PLEASE READ AND SIGN ONLY IF YOUR INSURANCE REQUIRES A REFERRAL

You are advised that the terms of your insurance contract requires you to obtain a referral form from your participating primary care physician before receiving the services you seek at our practice

Please be further advised that the provider you will see today has confirmed that if you proceed today to receive the services you seek in the absence of the required referral, the services rendered will not be "covered services" under the terms of your benefit contract and you will be responsible for payment of amounts up to the provider's FULL CHARGES for all services provided to you or your dependent. Please note that a referral cannot be backdated.

If you have any questions about the referral process under your benefit contract or are not sure whether a referral is required before receiving the services you seek today, please contact your insurance customer service at the phone number listed on the back of most insurance cards.

By signing below you are acknowledging your consent to pay directly to the provider all charges arising from your or your dependent's office visit today

Print name of patient and legal guardian (if applicable) _____
(Patient/Legal Guardian)

Contract Holder's Name _____

Contract Holder's ID No. _____

Accept and agreed _____

ENT FACULTY PRACTICE

Please print clearly

Patient Age: _____ If Patient is a minor please indicate:
Mother's Name: _____ Father's Name: _____
Mother's Occupation: _____ Father's Occupation: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell#: _____

Patient DOB: _____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single ___Married ___Other

Email Address: _____

Emergency Contact: _____ Phone #: _____

Employer Name: _____

Address: _____

Primary Dr: _____ Referring Dr: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Fax#: _____ Fax#: _____

Pharmacy Name _____ Phone: _____

Address _____

Prescription Coverage _____ ID# _____ Phone# : _____

Insurance Information:

Primary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder DOB _____ Policy Holder SS#: _____

Policy Holder Relation to Patient: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Address: _____

Phone # : _____

Policy Holder Name: _____ Relation to Patient: _____

Policy Holder DOB: _____ Policy Holder SS#: _____

***Patient Signature: _____ Date: _____

ENT FACULTY PRACTICE

New Patient Questionnaire

Date: _____

Name: _____ Age: _____

Reason for visit:

Length of time you had this problem: _____

Medical problems (please be specific)

Medication (Including Homeopathic, Herbal and OTC) **please be specific**

| Medication | Dosage | Frequency |
|------------|--------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medication Allergies: _____

Surgeries Date

(Please list all)

Family Medical History

Diabetes _____ No _____ Yes

High Blood Pressure _____ No _____ Yes

Heart Disease _____ No _____ Yes

Cancer _____ No _____ Yes

Other: _____

Social History

Do you Smoke ? _____ No _____ Yes How Much ? _____

Do you drink? _____ No _____ Yes How Much ? _____

Do you use IV Drugs _____ No _____ Yes How Much ? _____

Occupation: _____

Review of symptoms (Circle all that apply)

| | | | | | |
|-------------------------|----------------|---------------------|--------------------|------------------|------------------|
| General Fever | Chills | Night Sweats | Dizziness | None | Other: |
| Allergies | Hay-Fever | Dust | Pollen | Mold | None |
| | Other: _____ | | | | |
| Cardiovascular | Chest Pain | Heart Attack | Heart Failure | | |
| | Leg Swelling | High Blood Pressure | | None | |
| | Other: _____ | | | | |
| Endocrine | Diabetes | Thyroid | None | Other: | |
| Eyes | Blurry Vision | Double Vision | Itchiness | Photophobia | |
| | Blindness | None | Other: | | |
| Gastrointestinal | Nausea | Vomiting | Bleeding | Diarrhea | Weight Loss |
| | Liver Problems | None | Other: | | |
| Genitourinary | Pain | Frequency: | Bleeding | Burning | Kidney Stone |
| | Prostate | None | Other: | | |
| Hematologic | Easy Bruising | Anemia | Blood Transfusions | None | |
| | Other: _____ | | | | |
| Immunologic | HIV Positive | AIDS | None | Other: | |
| Lymphatic | Nodes | Lumps | None | Other: | |
| Musculoskeletal | <u>Pain</u> | <u>Swelling</u> | <u>Weakness</u> | <u>Stiffness</u> | <u>Arthritis</u> |
| | <u>None</u> | <u>Other:</u> | | | |
| Neurological | Weakness | Numbness | Memory Problems | | |
| | Vertigo | None | Other: | | |
| Ob/Gyn | Pregnant | Irregular Periods | Discharge | None | |
| | Other: | | Last Gyn Exam: | | |
| Psychiatric | Depression | Anxiety | Hallucinations | Suicidal | |
| | Drug Addiction | None | Other: | | |
| Respiratory | Asthma | Pneumonia | Cough | Sputum | Wheezing |
| | Tuberculosis | None | Other: | | |
| Skin | Rash | Lesion | Pain | None | Other: |

ENT FACULTY PRACTICE, LLP
OFFICE POLICY
PATIENT FINANCIAL RESPONSIBILITY

I agree to assume all financial responsibility for the medical care, treatment and other related services provided to myself and/ or to _____
by ENT Faculty Practice, LLP. (Name of Patient)

If my co-payment is not paid at the time of my visit I am responsible for an administrative charge of \$20.00 in addition to my co-pay.

If payment is not made today, I understand that any balance owed must be paid full within 30 days from the date of my bill; If payment is made later than 30 days from the date of my bill, I understand that I am responsible for interest charges, which will accrue at a rate of 1.5% per month.

I am responsible for the collection fees, attorney's fees and any other costs associated with collecting this bill or any of my bills in the future. If I fail to remit any fees due to ENT Faculty Practice, LLP. If a check I issue to ENT Faculty Practice, LLP is returned unpaid by my bank for any reason, I agree to be responsible for a returned check charge of \$25.00.

I am aware that ENT Faculty Practice, LLP cannot accept the responsibility of collecting insurance benefit. I am directly responsible to ENT Faculty Practice, LLP for payment of all balances due regardless of insurance coverage, ENT Faculty Practice, LLP agrees to complete routine medical insurance claims forms at no additional charge.

Signature of Responsible Party

Print Name of Responsible Party

Print Patients Name

Date