New York Eye and Ear Infirmary of Mount Sinai

Department of Otolaryngology-Head & Neck Surgery

We appreciate your cooperation in completing this form.

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

PATIENT INFORMATION

Last name:		**First:**		**Middle Initial:**	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		**Birth Date:**		**Sex:** ☐ M ☐ F	
Street Address/ PO Box:		**City:**		**State & Zip Code:**	
Email address:					
Cell/ Mobile phone:		**Home Phone:**		**Work Phone:**	**Ext:**
Employer Name:		**Employer Address:**		**Occupation:**	
* **Pharmacy Name:**		**Pharmacy Address:**			
Pharmacy Phone:		**Pharmacy Fax:**			

Race : ☐ American Indian ☐ Asian Indian ☐ Black ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Vietnamese ☐ Decline to Provide ☐ Other:

Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Chinese ☐ Other

REFFERAL SOURCE

Referring Source (Please check all that apply): ☐ Physician/Clinic ☐ Family/friend ☐ Clergy ☐ Employer/Coworker ☐ 800-MD-SINAI ☐ Mount Sinai Website ☐ Insurance ☐ No Referring MD ☐ Self ☐ **Other:**

☐ *Check if this is a **second opinion***

Referral Name:			
Referral E-mail:			
Referral Address:			
Referral Phone:		**Referral Fax:**	

OTHER TREATING PHYSICIANS

Primary Care Physician:			
Address:		Phone:	
Fax:			
Specialist Physician(s):			
Physician Name:		Address:	
Phone:		Fax:	
Physician Name:		Address:	
Phone:		Fax:	

New York Eye and Ear Infirmary of Mount Sinai

INSURANCE INFORMATION

(Please present your insurance card to the receptionist.)

Person responsible for bill:	Birth Date:	Address (if different):	Home Phone:
☐ Self			
Occupation:	**Employer:**	**Employer Address:**	**Employer Phone:**

Name of primary insurance:			
Subscriber's Name: ☐ Self	**Birth Date:**	**Group # :**	**Policy # :**
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child ☐ Other

SECONDARY INSURANCE (IF APPLICABLE)

Name of secondary insurance:	Subscriber's Name:	Group # :	Policy # :
Patient's relationship to subscriber:	☐ Self ☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Please notify in case of emergency:	Relationship to Patient:

☐ Check if address is the ***same*** as in patient information

Address:	City, State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, (see financial agreement). I also authorize the ***Department of Otolaryngology-Head & Neck Surgery*** and/or insurance company to release any information required to process my claims.

Patient/ Guardian signature:		**Date:**
Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

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AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

☐ Yes ☐ No (Please initial) _____

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. _____ (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 portion of the claim is not paid or only a portion of the claim is paid, I shall be responsible for payment of any balance as determined by my insurance company immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

☐ Yes ☐ No (Please initial) _____

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)

☐ Yes ☐ No (Please initial) _____

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 or can be provided to me upon request. I may choose to see an out-of-network provider and understand that I may be responsible for paying for this service.
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 the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed by this practice by contacting the office; I also understand that I can determine the health plans accepted by hospitals and facilities the providers in this practice utilize by contacting the hospital's website.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facilities" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians will be required for my care; and (2) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE

New York Eye and Ear Infirmary of Mount Sinai

Electronic Medication Access Consent form

In this Consent form, you can choose whether to allow **New York Eye and Ear Infirmary of Mount Sinai** (hereinafter NYEE) to obtain access to your medication history through computer networks operated by Surescripts, a provider of electronic prescribing services. These computer networks can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.
You may use this Consent Form to decide whether or not to allow NYEE to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**
If you check the "**I GIVE CONSENT**" box below, you are saying "Yes, NYEE's staff involved in my care may see and get access to all of my medication history through Surescripts."
If you check the "**I DENY CONSENT**" box below, you are saying "No, NYEE may not be given access to my medication history for any purpose."
This kind of sharing of medical records is called health or health information technology (health IT). To learn more about ehealth in New York State, go to www.ehealth4ny.og. The network NYEE would access based upon this consent is:

- Surescripts., which is a national provider of electronic prescribing services connecting physicians and hospitals with pharmacies

Please carefully read the information provided before making your decision.
Your consent choices:

I give consent for NYEE to access my electronic health information through Surescripts in connection with providing me any health care services.

I deny consent for NYEE to access my electronic health information through Surescripts for any purpose, even in a medical emergency.

NOTE: Unless you check this box, New York State law allows the people treating you in an emergency to get access to your medical records, including medical records included through Surescripts.

_____	_____
Name (Print)	Date of Birth
_____	_____
Signature of patient or legal representative	Date
_____	_____
Print Name of legal representative (if applicable)	Relationship to Patient (if applicable)

New York Eye and Ear Infirmary of Mount Sinai

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.

Signature:	
Today's Date:	

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

Televox Appointment Reminders

New York Eye and Ear Infirmary of Mount Sinai aims to provide all patients with a reminder about their appointment. In addition to a phone call, our patients have the option to receive a text message and/or an email reminder.
Please provide us with your preferred contact method.

Email:

Text message*:

To opt into Text Message reminders, please text (NYEE) to (622622).

*** Please note, all carrier charges will apply to text message notifications.**

New York Eye and Ear Infirmary of Mount Sinai

NEW YORK EYE AND EAR INFIRMARY OF MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires hospitals to obtain your written authorization prior to informing you of educational programs and philanthropic initiatives that support the work of your doctors. Your authorization below permits Mount Sinai doctors, development officers, trustees, and other staff to learn the name(s) of your health care provider(s) for the purpose of contacting you about educational and philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed – that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Compliance Officer in the Mount Sinai
Development Office at (212) 373-4967.

Thank you.

I authorize that the Mount Sinai Hospital and Mount Sinai School of Medicine ("Mount Sinai") may disclose the name of my health care provider(s) to Mount Sinai development officers, and other staff, volunteers, and consultants and contractors assisting in fund raising efforts, for the purpose of contacting me about Mount Sinai educational efforts (e.g., lectures, informational newsletters) and fund raising opportunities. I understand that this authorization will expire five (5) years from the date of my signature below. I also understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third party vendors for any purpose other than that expressed above. I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

Patient Name:	**Patient Signature:**
Today's Date:	**Appointment Date:**

Personal Representative Name:	Personal Representative Authority:	Responsible Party Signature:

CONTINUITY OF CARE DOCUMENT

The Continuity of Care Document (CCD) allows our facility to comply with federal regulations related to providing other physicians and health care facilities with a summary of your clinical history. This information includes: Patient name, sex, date of birth, race, ethnicity, preferred language, smoking status, problems, medications, medication allergies, laboratory tests, laboratory values/results, vital signs, and other vital information.

To OPT OUT of the Continuity of Care Document Sign Below:

Patient Name:	**Patient Signature:**
Today's Date:	**Appointment Date:**

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PATIENT MEDICAL HISTORY QUESTIONNAIRE: *Kindly complete this form in order to provide you with the best possible care.*

Patient's Last Name:		First:		Date:	

What is the reason for this visit?	

General (weight change, fatigue, fever, loss of appetite)	☐ Yes ☐ No	(Please specify)	
Heart disease (heart attack, congestive heart failure, angina, irregular heartbeat/arrhythmia)	☐ Yes ☐ No	(Please specify)	
High blood pressure or low blood pressure	☐ Yes ☐ No	(Please specify)	
Lung disease, including asthma, emphysema or shortness of breath	☐ Yes ☐ No	(Please specify)	
Blood disorder (including problems with bleeding, clotting or easy bruising)	☐ Yes ☐ No	(Please specify)	
Diabetes or low blood sugar	☐ Yes ☐ No	(Please specify)	
Thyroid disease	☐ Yes ☐ No	(Please specify)	
Stroke	☐ Yes ☐ No	(Please specify)	
Neurologic disorder (e.g., seizure, frequent headache, dizziness, fainting)	☐ Yes ☐ No	(Please specify)	
Psychological/psychiatric disorder	☐ Yes ☐ No	(Please specify)	
Gastrointestinal problems (including ulcer, diverticulitis, spastic colon , bleeding from rectum)	☐ Yes ☐ No	(Please specify)	
Liver Disease	☐ Yes ☐ No	(Please specify)	
Kidney or bladder disease	☐ Yes ☐ No	(Please specify)	
Frequent infection (including pneumonia, bronchitis, urinary tract infection)	☐ Yes ☐ No	(Please specify)	
Eye problems or diseases (e.g. glaucoma, cataract)	☐ Yes ☐ No	(Please specify)	
Arthritis, muscle, bone disorder (including fracture)	☐ Yes ☐ No	(Please specify)	
Immune system disorder (including lupus, HIV, AIDS)	☐ Yes ☐ No	(Please specify)	
History of cancer	☐ Yes ☐ No	(Please specify)	

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Patient's Last Name:		First:		Date:	

Skin disorder (including hives, rash, swelling)	☐ Yes ☐ No	(Please specify)	
Anesthetic complications (include dental anesthesia)	☐ Yes ☐ No	(Please specify)	
Other	☐ Yes ☐ No	(Please specify)	
Do you have a history of alcohol use? If **YES,** how much did/do you drink?	☐ Yes ☐ No	How often?	
Do you have a history of smoking? If **YES,** how much did/do you smoke?	☐ Yes ☐ No	How often?	
Do you have a history or drug abuse? If **YES,** how much did/do you use?	☐ Yes ☐ No	How often?	
Family History Are there any conditions or diseases related to your complaint that run in your family?	☐ Yes ☐ No	(Please specify)	
Surgical History Have you had any type of surgery (e.g., heart, abdominal, orthopedic, oral, eye, transplant)?	☐ Yes ☐ No	(Please specify)	

Allergy History Have you ever had a severe allergic reaction (e.g., bee stings, food {milk, nuts}?	❑ Yes ☐ No	(Please specify)	
Have you ever had an allergic action to any medications (antibiotics, Codeine, etc)?	☐ Yes ☐ No	(Please specify)	
Medication History Please list all medications you are now taking. How much/how often?			
Immunizations: *Pneumovax* (pneumonia Vaccine)	☐ Yes ☐ No	Date:	
Influenza ("Seasonal Flu Shot")	☐ Yes ☐ No	Date:	

Patient Name:		Patient Signature:	Date:	