

WEILL CORNELL PHYSICIANS

Doctor's Name: WARD MD, ROBERT F	Provider # 6045	Appt Date:	Appt Time:	Appt #
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REGISTRATION FORM

Instructions: Fill in the blanks. Replace any wrong or outdated information by crossing it out and noting the change.

First Name, MI		Last Name		Sex	Marital	DOB	Age	SSN
Address		City	State	Zip	NYH Chart #	IDX MRN		
Home Phone	Fax#	Cell Phone		Email Address		Patient's Birthplace		
Mother's Name		Mother's DOB (Peds Pts Only)		Mother's Home Phone		Mother's Work Phone		
Father's Name		Father's DOB (Peds Pts Only)		Father's Home Phone		Father's Work Phone		
Employer Name (Primary Policy Holder)				Employer Address				
City	State	Zip	Work Phone #		Work Fax #			
Emergency Contact's Name			Relationship		Home Phone		Work Phone	

Referring Physician's Name					
Address		City	State	Zip	Phone
Primary Care Physician Name					
Address		City	State	Zip	Phone
OB/GYN Name (female patients)					
Address		City	State	Zip	Phone

PRIMARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date
SECONDARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Weill Cornell Physicians, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Weill Cornell Physicians sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

{ } (Medicare) 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 SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

Signature of Patient or Authorized Guardian

Date

MEDICAL INFORMATION FORM

Patient's Name: _____ **Date of Visit:** _____

Date of Birth : _____ **Age :** _____ **Weight:** _____ **Height :** _____

Reason for the visit: _____

Children's Names & Birthdates : _____

Medications & Dosage (include over-the-counter, vitamins, aspirin, herbal medications or birth control):

Pharmacy Name _____ **Address:** _____ **Tel#** _____

Please list all prior major illnesses / surgeries (with years) :

Operations	1. _____	2. _____	3. _____
Hospitalizations	1. _____	2. _____	3. _____
Illnesses/Injuries	1. _____	2. _____	3. _____

Please list any allergies to medications, Latex or Foods : _____

Reactions: _____

Past or current Medical Conditions (circle Y for yes, N for no):

<i>Constitutional</i>		<i>Cardiovascular</i>		<i>Genitourinary</i>	
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	
hearing loss	Y N	Endocrine		arthritis	Y N
ear pain	Y N	diabetes	Y N	chronic back pain	Y N
ringing in ear	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 problems	Y N
voice changes	Y N	anemia	Y N		

If Yes to any of the above, please explain: _____

Family Health/Social History (check)? Heart Disease Diabetes Cancer Other _____

Which family member? _____

Do you drink alcohol? ___ No, never ___ No, but I used to ___ Yes How many drinks? ___ / day or wk
 Do you smoke? ___ No, never ___ No, but I used to (quit in yr. ___) Packs per day? ___ x ___ years
 Do you use illicit drugs? ___ No, never ___ No, but I used to ___ Yes Which? _____

Reviewed by: _____
 Robert F. Ward, M.D.



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**Department of Otorhinolaryngology
Financial Policy**

Welcome to the Department of Otorhinolaryngology. The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

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 questions 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 as outlined by your plan coverage. The co-payment is typically listed on your insurance card. The Medical College will then forward a bill to your insurance carrier who will inform the College if any deductible or percentage of payment is due from you. You will receive written notification of such decision any 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 will be responsible for full payment at the time of service.

Non-Participating Plans

In this scenario the physician you will see does not participate with your insurance plan. Payment for services is due at the visit. You will then be given a Health Insurance Claim Form which you can mail to your insurance company to seek reimbursement directly to you.

Medicare

Drs. Kacker, Kuhel, Kutler, LaBruna, Lin, Prasad, Reisacher, Roure, Selesnick, Stewart, Sulica, and Voigt accept Medicare assignment, as do our Audiologist, Joseph Montano, Marjorie Klaskin, Michelle Kraskin and Hannah Schonfield. For their services, Medicare will be billed directly. Medicare will determine appropriate payment and if a deductible or any percentage of payment is due from you. Typically, Medicare requires 20% of the payment – along with any unpaid deductible – to be paid by you, or by your secondary insurance, if you have one.

Some of the ENT physicians and Audiologist in the practice do not accept Medicare assignment. If the provider is not listed above you will be responsible for payment at the time of service. Your claim will then be forwarded to Medicare who will determine appropriate reimbursement.

Payment

Cash, Check, Mastercard, Visa, Discover, American Express and NYCE cards 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.

X
Signature of the patient or Responsible party

X
Date