

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 Replace any wrong or outdated information by crossing it out and noting the change.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

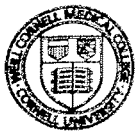
ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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



Patient Name: _____
(Last, First MI) Nickname

Mother's Name: _____ Father's Name: _____

Pediatrician: _____ Referring Physician: _____

Pharmacy Name: _____ Telephone: _____ Address: _____

Reason for today's visit: _____

Past Medical History: _____

Prior Surgeries: _____

Hospitalizations: YES NO If YES, list reason: _____

Current Medications & Dosage: _____

List any Allergies to medications, Latex or Foods: _____

Reactions: _____

Birth History:

Was your child born full term? YES NO Medical problems at birth? YES NO _____

Has your child been on a ventilator? YES NO Circle one: Normal delivery or Cesarean Section

Social History: Anyone smoke in the home? YES NO Is your child in daycare or school? YES NO

Family Illnesses: _____

REVIEW OF SYSTEMS

Fever	YES	NO	<u>Eyes:</u> Vision problems	YES	NO
Issues with weight/nutrition/feeding	YES	NO	<u>Cardiovascular:</u> Heart problems	YES	NO
Genetic disorder	YES	NO	<u>Musculoskeletal:</u> Developmental abnormalities?	YES	NO

Ear, Nose and Throat:

Concern with possible hearing loss	YES	NO	Difficulty sleeping at night	YES	NO
Speech development issues/delay	YES	NO	Snoring (if yes, answer below)	YES	NO
Balance disturbance	YES	NO	Loud and obstructive	YES	NO
Nosebleeds	YES	NO	Noisy breathing/Stridor?	YES	NO
Nasal congestion/Mouth Breathing	YES	NO	Working to breathe	YES	NO
Liquids come out of nose when drinking	YES	NO	Daytime tiredness	YES	NO

In the past 6 months number of ear infections____, tonsil infections____, sinus infections____

In the past 12 months number of ear infections____, tonsil infections____, sinus infections____

Pulmonary:

Asthma	YES	NO
Cough	YES	NO
Bronchitis/Pneumonia	YES	NO

Allergy / Immunology:

Environmental / Food allergy	YES	NO
Immunologic disorder	YES	NO
Previous allergy testing:	YES	NO

Neurologic:

Developmental delay	YES	NO
Hypotonia	YES	NO
Hyperactivity	YES	NO

Endocrine: Thyroid abnormalities YES NO

Gastrointestinal:

Gastroesophageal reflux	YES	NO
Recurrent spitting up / vomiting	YES	NO

Hematology:

Easy bruising/bleeding	YES	NO
Family history of bleeding problems?	YES	NO

Genitourinary: Does your child bedwet? YES NO

Integumentary: Any skin abnormalities YES NO

Psychiatric: Psychiatric conditions YES NO

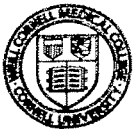
The above information is accurate to the best of my knowledge.

X Signature of Parent or Guardian	Print Name of Parent or Guardian	Relationship to patient	Date
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FOR PHYSICIAN'S USE ONLY:

I have reviewed the above information with the patient.

Physician Signature	Date
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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