

Appointment Information				
Doctor's Name: MODI MD, VIKASH	Provider # 6027	Appt Date:	Appt Time:	Appt #

REGISTRATION FORM

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 Replace any wrong or outdated information by crossing it out and noting the change.

Patient Information								
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 #		
PERSON TO CONTACT IN CASE OF AN EMERGENCY								
Emergency Contact's Name			Relationship		Home Phone		Work Phone	

Your Physicians					
<i>Referring Physician's Name</i>					
Address		City	State	Zip	Phone
<i>Primary Care Physician Name</i>					
Address		City	State	Zip	Phone
<i>OB/GYN Name (female patients)</i>					
Address		City	State	Zip	Phone

Your Insurance Information					
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



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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 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 98insurance 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 and 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 in your insurance plan. Payment for services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Medicare

Drs. Kacker, Kuhel, Kutler, LaBruna, Modi, Pearlman, Prasad, Reisacher, Roure, Selesnick, Stewart, Sulica, and Voigt accept Medicare assignment, as do our Audiologists, Joseph Montano, Jennifer Aboud, Elaine Henry, Marjorie Klaskin, Michelle Kraskin and Hannah Shonfield. For their services, Medicare will be billed directly. Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance.

Some of the ENT physicians and Audiologists 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 and reimbursed directly to you.

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



Patient Name: _____
(Last, First MI) Nickname

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

Sex: _____ Age: _____ Date of Birth: _____

Pediatrician: _____

Referring Physician: _____

Reason for today's visit: _____

Past Medical History

Please list any prior major illnesses and/or injuries:

Current Medications:

Medication Allergies: YES NO If YES, to what: _____

Are the immunizations up to date? YES NO

Surgery:

Has your child ever had surgery? If YES, list age(s) and reason: _____

Family History

Significant illnesses in the Family:

Family Member

List significant illnesses

Social History

Your child lives at home with:

Mother YES NO Father YES NO Pets YES NO

Siblings YES NO ___# of Brothers ___# of Sisters

Does anyone smoke at home? YES NO _____

Is your child in Daycare or School? YES NO What grade? _____

Birth History:

Was your child born full term? YES NO If NO, how early? _____

Medical problems at birth? YES NO _____

Was your child on a ventilator? YES NO If YES, how long? _____

Circle one: Normal delivery or Cesarean Section _____

Hospitalizations:

Except at birth, has your child been hospitalized? YES NO

If YES, list age(s) and reason: _____

REVIEW OF SYSTEMS

General:

Fever YES NO _____
 Issues with weight/nutrition/feeding YES NO _____
 Genetic disorder YES NO _____

Ear, Nose and Throat:

Concern with possible hearing loss YES NO _____
 Speech development issues/delay YES NO _____
 Balance disturbance YES NO _____
 Nosebleeds YES NO _____
 Nasal congestion YES NO _____
 Nasal regurgitation when eating YES NO _____

Number of ear infections in the past 6 months: _____, Number of ear infections in the past year _____
 Number of sinus infections in past 6 months: _____, Number of sinus Infections in the past year _____
 Number of tonsillitis episodes in the past year: _____, Episodes 2 years ago _____, Episodes 3 year ago _____

Difficulty sleeping at night YES NO _____
 Snoring (if yes, answer below) YES NO _____
 Loud and obstructive YES NO _____
 Working to breathe YES NO _____
 Mouth breathing YES NO _____
 Daytime tiredness YES NO _____
 Hyperactivity YES NO _____

Eyes: Vision problems YES NO _____

Neurological:

Developmental delay YES NO _____
 Hypotonia YES NO _____

Cardiovascular: Heart problems YES NO _____

Respiratory:

Asthma / reactive airway disease YES NO _____
 Noisy breathing/Stridor YES NO _____
 Cough YES NO _____
 Bronchitis/Pneumonia YES NO _____

Allergic / Immunologic:

Environmental / Food allergy YES NO _____
 Immunologic disorder YES NO _____
 Previous allergy testing: YES NO If YES, when? _____

Gastrointestinal:

Gastroesophageal reflux YES NO _____
 Recurrent spitting up / vomiting YES NO _____

Endocrine: Thyroid abnormalities YES NO _____

Hematalogy:

Easy bruising/bleeding YES NO _____
 Do any blood relatives have bleeding problem? YES NO _____

Musculoskeletal: Developmental abnormalities YES NO _____

Genitourinary: Does your child bedwet? YES NO If yes, how many times a week? _____

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	Date
_____	_____
Print Name of Parent or Guardian	Relationship to patient

FOR PHYSICIAN'S USE ONLY:

I have reviewed the above information with the patient.	
_____	_____
Physician Signature	Date