

DEPARTMENT OF OTORHINOLARYNGOLOGY

**WEILL
CORNELL
PHYSICIANS**

Appointment Information

Doctor's Name Samuel Selesnick, MD	Provider # 6052	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 Replace any wrong or outdated information by crossing it out and noting the change.

Patient Information										
First Name, MI			Last Name			Sex	Marital	DOB		SSN
Address					City		State		Zip	
Home Phone		Home Fax#		Cell Phone		Email Address		NYH Chart #	IDX MRN	
Mother's Name		Mother's DOB (Peds Pts Only)		Father's Name		Father's DOB (Peds Pts Only)		Patient's Birthplace		
Employer Name		Employer Address			City, State		Zip	Work Phone	Work Fax#	
Reason for visit										
PERSON TO CONTACT IN CASE OF AN EMERGENCY										
Emergency Contact's Name				Relationship		Home Phone		Work Phone		

Your Physicians					
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

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

Samuel Selesnick, M.D., F.A.C.S.

Date of visit: ___/___/___

Patient's Name: _____

Date of Birth: ___/___/___ Age: _____ Weight: _____ Height: _____

Reason for the visit: _____

Occupation/Employer: _____

Marital Status: _____ Name of spouse/Significant other: _____

Children's Names & Birthdates (if applicable): _____

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

Operations: 1. _____ 2. _____ 3. _____

Hospitalizations: 1. _____ 2. _____ 3. _____

Illnesses/Injuries: 1. _____ 2. _____ 3. _____

Family 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/week

Do you smoke? No, never No, I quit in _____ Yes Packs per day? ___x ___ years.

Do you use illicit drugs? No, never No, but I used to Yes Which drug? _____

Have you experienced any of the following? (Circle Y or N or N/A)

Table with 3 columns: Constitutional, Cardiovascular, Genitourinary, Eyes, Gastrointestinal, Skin, Ear/Nose/throat, Endocrine, Musculoskeletal, Neurologic, Respiratory, Hematology, Psychiatric. Each cell contains a symptom and 'Y N' or 'Y N'.

If you answered YES to any of the above, please explain: _____

Reviewed by: _____

Samuel Selesnick, M.D., F.A.C.S.



Weill Cornell Medical College

Department of Otolaryngology - Head & Neck Surgery

1305 York Avenue, 5th Floor
New York, NY 10021

Referring Physician, Medication and Pharmacy Information Form

Patient's Name: _____ Date: _____

The name and address of your internist or referring doctor:

Physician's Name: _____

Address: _____

Telephone: _____

Fax: _____

Medications:

Do you have allergies to Medications? No Yes (please list): _____

Please List all medications that you are taking (Including over-the-counter medications such as: eye drops, aspirin, motrin, nasal sprays, vitamins, herbal remedies, birth control pills, etc.)

Medication	Dosage (mg, teaspoons, etc)	Frequency

Pharmacy Information:

In order to expedite prescription service if required we would like to have your pharmacy information on file.

Pharmacy Name: _____

Address: _____

Telephone: _____

Fax: _____

Patient's Signature: _____



Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Department of Otolaryngology- Head and Neck Surgery
New York Presbyterian Hospital
Weill Cornell Medical Center

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New York, NY 10021

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 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 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 may have to reschedule your appointment.

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. Brown, Cohen, Kacker, Kuhel, Kutler, Levinger, McCarn, Pearlman, Prasad, Reisacher, Selesnick, Stewart, Sulica, and Voigt accept Medicare assignment, as do our Audiologists and our Speech/Voice Pathologists, Joseph Montano, Thomas Murry, Lisa Marie Bizzarro, Christine Estes, Meredith Fetch, Elaine Henry, Marjorie Klaskin, Yvonne Knapp, Michelle Kraskin, Ellen Lettrich, Gayle Morris, Ann Weisenberg, Allison Shapiro 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.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

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



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**NewYork-Presbyterian Hospital
Weill Cornell Medical Center**

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October 6, 2011

Dear Patient:

According to new Federal guidelines, patients should have their blood pressure checked on a periodic basis by each of their medical providers.

While we need to comply with these guidelines, please realize that blood pressure management is not in the purview of our practice.

If you feel that your blood pressure today is not consistent with your usual blood pressure, please convey this to your general practitioner or cardiologist.

Sincerely,

The Department of Otolaryngology/Head and Neck Surgery