

# DEPARTMENT OF OTORHINOLARYNGOLOGY

**WEILL  
CORNELL  
PHYSICIANS**

Doctor's Name W. Shain Schley, MD	Provider # 6005	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 Replace any wrong or outdated information by crossing it out and noting the change.*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	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							

Emergency Contact's Name				Relationship	Home Phone	Work Phone
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<b>Referring Physician's Name</b>					
Address		City	State	Zip	Phone
<b>Primary Care Physician Name</b>					
Address		City	State	Zip	Phone
<b>OB/GYN Name (female patients)</b>					
Address		City	State	Zip	Phone

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

W. Shain Schley, M.D.

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)

Constitutional

weight gain/loss (>15lbs) Y N

constant night sweats Y N

Eyes

double vision Y N

glaucoma Y N

Ear/Nose/throat

hearing loss Y N

ear pain Y N

ringing in ears Y N

balance problems Y N

hearing aid Y N

difficulty breathing Y N

nosebleeds Y N

nasal drainage Y N

sinus problems Y N

snoring Y N

voice changes Y N

Cardiovascular

heart attack Y N

↑ blood pressure Y N

heart murmur Y N

Gastrointestinal

chronic diarrhea Y N

heartburn Y N

Endocrine

diabetes Y N

thyroid disease Y N

autoimmune disease Y N

Neurologic

headaches Y N

seizures Y N

stroke Y N

Hematology

bruise easily Y N

anemia Y N

Genitourinary

frequent urination Y N

prostate problems n/a Y N

Skin

past skin cancer Y N

past radiation therapy Y N

Musculoskeletal

arthritis Y N

chronic back pain Y N

Respiratory

asthma/emphysema Y N

chronic cough Y N

tuberculosis Y N

Psychiatric

anxiety Y N

depression Y N

sleep apnea Y N

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by: \_\_\_\_\_

W. Shain Schley, M.D.



**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  
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Telephone: 646-962-5300  
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1305 York Avenue, 5th Floor  
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, McCam, 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



**Weill Cornell Medical College**

**┌ New York-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