Center For Sinus & Allergy Care
Michael J. Parker, MD
Lori Woods, NP
Kim Olrich, FNP
Jessica Lockwood, PA
5639 West Genesee Street Camillus NY 13031
(315) 468-6888 Fax (315)468-6892

Dear_____,

Welcome to our practice! You have been scheduled for an appointment on _____ , at _____ with _____ . Please complete the attached questionnaire and bring it to your initial visit, along with your most current insurance card and a referral/prior authorization from your referring physician. Also, please bring a list of all medications with dosages that you are currently taking.

If you have had any tests (CT, MRI,Xray), please bring the disks, films, and/or images with you (written reports are not sufficient) to your first appointment. Failure to do so may cause a delay in your appointment.

Financial Policy

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals. You should be knowledgeable of any deductibles, co-payments and/or co-insurances. As a courtesy, we will bill a patient's insurance.

All health plans are not the same and do not cover the same services. There is no guarantee that your insurance company will cover your visit and/or tests. ***It is your responsibility to obtain prior authorization for procedures and/or medical equipment.*** In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. For procedures and/or medical equipment you may be required to pay a deposit. The balance of the charges is due upon receipt of a statement from our office.

**** We do not participate with Workman's Compensation Insurance ****

Co-payments/Co-insurance/Deductibles - are due at time of service.

Payments - are due at the time services are provided, or upon receipt of a statement from our billing office. Unpaid balances are billed monthly. We accept payment in the form of cash, check, money order or credit card (Visa, Mastercard, Discover). If after 90 days either a payment or payment arrangement has not been made, the account may be referred to a collection agency.

No Show Policy - Due to high patient demand, and limited availability of appointments, we have instituted a $50 fee for missed appointments without a 24 hr notice.

Returned Checks - A $15 fee will be assessed for a check returned by your bank.

With our team approach you may see the Physician from time to time. However you may see our Nurse Practitioners, Lori Woods and Kim Olrich or our Physician Assistant, Jessica Lockwood more frequently for your follow up visits.

I, _____ , D.O.B. _____ have read, understand and agree to the terms stated above.

Signature: _____ Date: _____

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Patient Name:	**Date of Birth:**	**Email Address:**
Street Address:	**City:**	**State, Zip:**
Home Phone: / **Work Phone:**	**Cell Phone:**	**Preferred Contact Number:** ☐ Home ☐ Work ☐ Cell
Gender: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced	
Race: ☐ American Indian or ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or ☐ Other Pacific Island ☐ White ☐ Unknown/Not Reported		
Pharmacy:	**Pharmacy Address:**	**Pharmacy Phone Number:**
Name of Emergency Contact:	**Relationship:**	**Phone Number:**
Guarantor's Name:	**Relation to Patient:**	**Date of Birth:** / **Phone Number:**
Address:		**City, State and Zip:**

Primary Insurance Name:	**Primary Insurance Policy # :**	**Group #**	**Co-Pay Specialist:**	**Co-Pay Test**
Primary Insurance Policy Holder:	**Policy Holder Date of Birth:**	**Relation to Patient:**		
Secondary Insurance Name:	**Secondary Insurance Policy#:**	**Group#:**	**Co-Pay Specialist :**	**Co-Pay Test**
Secondary Insurance Policy Holder:	**Policy Holder Date of Birth:**	**Relationship to Patient:**		

Please List other Medical Provider you are seeing currently:

Primary Care Physician Name:	**PCP Phone:**	**Provider 2 Name:**	**Provider 2 Phone:**

Were you referred to our office by: ☐ Emergency Room ☐ Primary Care ☐ Other _____

HIPAA DOCUMENTATION

1. **I acknowledge that I have been given the opportunity to read and/or receive a copy of FamilyCare Medical Care Group's Privacy Notice. Y N**

2. Leave Appointment messages on:		Leave other medical info on:	
Answering machine	Y N	Answering machine?	Y N
Office Voicemail	Y N	Office Voicemail	Y N
w/Person Listed below	Y N	w/Person Listed below	Y N
Cell Phone	Y N	Cell Phone	Y N

3. **Person(s) authorized to discuss the above:**

Name:	**Relationship:**
Name:	**Relationship:**

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Family Care Medical Group and acknowledge that I am financially responsible for appropriate deductibles, copayments and non-covered items, including those charges which have been denied by my insurance carrier. I understand it is my responsibility to verify with my insurance plan that medical services provided by Center for Sinus and Allergy Care will be covered by my plan. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company and health care provider(s) in accordance with HIPAA guidelines.

Signature of Patient or Guarantor: _____ **Date:** _____

Center for Sinus & Allergy Care

Patient Clinical/Medical Information

Patient's Name_____ Date of Birth_____

Referring Physician_____

Reason for Appointment_____

Please list medical conditions_____

Please list any past surgeries_____

Please list medications you are currently taking, including dosage & frequency (include beta blockers)

_____

_____

Please list medication allergies & type of reaction_____

_____

Please list previous diagnostic tests, i.e. x-rays, CT scans, etc.:_____

_____

Please list environmental or food allergies_____

_____

If injury, date and time of accident_____

If injury, please describe how injury/accident occurred_____

_____

If Worker's Compensation injury, where did accident occur?_____

Are you presently working ? ☐ Yes ☐ No (Please Circle) FT PT

If not working, first day of disability_____

Do you have any restrictions at work ?_____

In case of emergency, please contact_____ Relationship_____

Address_____ Phone _____

Patient Signature_____ Date_____

Patient's Name_____ Date_____ DOB_____

PMHx: Do you have or have you had:

Diabetes ☐ Yes ☐ No
If Yes, Explain_____

Hypertension ☐ Yes ☐ No
If Yes, Explain_____

Stroke ☐ Yes ☐ No
If Yes, Explain_____

Phlebitis ☐ Yes ☐ No
If Yes, Explain_____

Cancer ☐ Yes ☐ No
If Yes, Explain_____

Ulcers ☐ Yes ☐ No
If Yes, Explain_____

Heart Valve Disease ☐ Yes ☐ No
If Yes, Explain_____

Heart Attack ☐ Yes ☐ No
If Yes, Explain_____

Angina ☐ Yes ☐ No
If Yes, Explain_____

Congestive Heart Failure ☐ Yes ☐ No
If Yes, Explain_____

Pneumonia ☐ Yes ☐ No
If Yes, Explain_____

TB ☐ Yes ☐ No
If Yes, Explain_____

Emphysema ☐ Yes ☐ No
If Yes, Explain_____

Asthma ☐ Yes ☐ No
If Yes, Explain_____

Kidney Disease ☐ Yes ☐ No
If Yes, Explain_____

HIV/AIDS ☐ Yes ☐ No
If Yes, Explain_____

Hepatitis ☐ Yes ☐ No
If Yes, Explain_____

Bleeding Disorder ☐ Yes ☐ No
If Yes, Explain_____

Complete Review of Systems: Do you have problems with:

Headache ☐ Yes ☐ No
If yes, Explain_____

Blurred Vision ☐ Yes ☐ No
If Yes, Explain_____

Dizziness ☐ Yes ☐ No
If Yes, Explain_____

Ears ☐ Yes ☐ No
If Yes, Explain_____

Sinuses ☐ Yes ☐ No
If Yes, Explain_____

Throat ☐ Yes ☐ No
If Yes, Explain_____

Chest Pain ☐ Yes ☐ No
If Yes, Explain_____

Cough ☐ Yes ☐ No
If Yes, Explain_____

Heartburn ☐ Yes ☐ No
If Yes, Explain_____

Diarrhea ☐ Yes ☐ No
If Yes, Explain_____

Constipation ☐ Yes ☐ No
If Yes, Explain_____

Bloody Stools ☐ Yes ☐ No
If Yes, Explain_____

Weight Loss ☐ Yes ☐ No
If Yes, Explain_____

Complete Family History:

Are your parents alive? ☐ Yes ☐ No
Mother
Father
If no, please explain_____
_____

If no, what was the cause of death ?
Mother_____
Father_____

How many brothers and sisters do you have?
Brother(s)_____ Sister(s)_____

Are they healthy ? ☐ Yes ☐ No
If no, explain_____
_____

Social History

Do you smoke? ☐ Yes ☐ No
How much?_____
How long?_____

Drink Alcohol? ☐ Yes ☐ No
How much?_____
How long?_____

Non-prescription drugs?

Arthritis ☐ Yes ☐ No
If yes, Explain_____

Rashes ☐ Yes ☐ No
If yes, Explain_____

Seizures ☐ Yes ☐ No
If yes, Explain_____

Blackouts ☐ Yes ☐ No
If yes, Explain_____

Migraines ☐ Yes ☐ No
If yes, Explain_____

Paralysis ☐ Yes ☐ No
If yes, Explain_____

Numbness ☐ Yes ☐ No
If yes, Explain_____

Short of Breath ☐ Yes ☐ No
If yes, Explain_____

Vomiting Blood ☐ Yes ☐ No
If yes, Explain_____

Pain with urination ☐ Yes ☐ No
If yes, Explain_____

Difficulty Urinating ☐ Yes ☐ No
If yes, Explain_____

Frequent Urination ☐ Yes ☐ No
If yes, Explain_____

Females only:
Vaginal bleeding or discharge ☐ Yes ☐ No

If yes, Explain_____

Date of last period_____

Are you pregnant ? ☐ Yes ☐ No

Does anyone in family suffer from:

Hearing Loss ☐ Yes ☐ No
If yes, Explain_____

Diabetes ☐ Yes ☐ No
If yes, Explain_____

Heart Disease ☐ Yes ☐ No
If yes, Explain_____

Lung Disease ☐ Yes ☐ No
If yes, Explain_____

Fever with anesthesia ☐ Yes ☐ No
If yes, Explain_____

Bleeding Disorders ☐ Yes ☐ No
If yes, Explain_____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Member Liability Waiver

NOTE: If your insurance does not allow for "**D**" listed below provided on , you may have to pay. Your insurance does not allow for everything, even some care that you or your health care provider have good reason to think you need.

D.	E. Reasons Your Insurance May Not Allow (including but not limited to)	F. Estimated Cost
	Not Being Medically Necessary **Experimental** **Investigational** **Cosmetic**	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the "**D**" listed above.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the "**D**" listed above. I may be asked to pay now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB) by my insurance company. I understand that if my insurance doesn't allow, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB. If my insurance does allow, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **"D"** listed above, but do not bill my insurance. I may be asked to pay now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I don't want the **"D"** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would allow.**

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or your insurance billing, call the phone number on the back of your member ID Card.

Signing below means that you have received and understand this notice.

I. Signature:	J. Date:

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.