

# New Patient Registration Package

## Michael Rothschild, MD

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Hello, and welcome to my office! I know that your time is valuable, so I have prepared this package of documents to help speed up the registration process. By filling out these forms before your first visit, we can keep the time you spend in the waiting room as short as possible. To save even more time, feel free to fax or email them ahead of time. The fax number is (212) 996-2703, or you can email them to [staff@parkavenueent.com](mailto:staff@parkavenueent.com)

There are four main documents in the registration package:

- 1) New Patient Registration Form (1 page)- Please fill this out as completely as possible, especially the sections regarding your child's primary care doctor. Insurance information is also important, so that we can help ensure that your policy applies to the cost of your visit ahead of time.
- 2) Medical History Form (1 page)
- 3) Notice of Privacy Practices (3 pages)- Effective as of April 14, 2003, there are a set of federal regulations (HIPAA) concerning the appropriate use of information related to health care. Part of these regulations stipulate that you must be informed of the impact of this legislation, so you will be asked to sign a form to acknowledge receipt of this document. Feel free to contact us with any questions, since we are not allowed to provide care unless these guidelines are complied with. This form is for your information only- you do not need to return it to us.
- 4) Acknowledgement of Financial and Privacy Policies (1 page)- This document outlines the policies of our practice with regard to health insurance, payment for services and patient privacy. Please complete and sign this form, acknowledging that you have received our notice of privacy practices, and that you understand our office policies.

I hope that getting this paperwork done ahead of time makes your visit easier. Please feel free to contact me if you have any further questions.

Best Wishes,

Michael Rothschild, MD

**MICHAEL ROTHSCHILD, MD**

**NEW PATIENT REGISTRATION FORM**

DATE: \_\_\_\_\_

**PLEASE PRINT**

**PATIENT INFORMATION**

Name of Patient \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of Patient \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Patient lives with  Parents  Other \_\_\_\_\_

Siblings in our practice \_\_\_\_\_

Parent Name \_\_\_\_\_

Parent Name \_\_\_\_\_

Parent Work Phone \_\_\_\_\_

Parent Work Phone \_\_\_\_\_

Parent Cell Phone \_\_\_\_\_

Parent Cell Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Relative or friend, not living in same household \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**BILLING: Please complete for policyholder (subscriber) or person otherwise responsible for bill**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION:** Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for all policies. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. If your coverage is contingent on a second opinion, or pre-admission approval, be sure to let us know.

Primary Insurance Company \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Patient Relationship to Subscriber (please check one):

Patient Relationship to Subscriber (please check one):

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

ID # \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

**Medical Contact Information**

Name of Primary Care Doctor / Pediatrician \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_

Doctor's Phone \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Pharmacy Address \_\_\_\_\_

Other treating doctor or referral source \_\_\_\_\_

# Medical History Form

**Michael Rothschild, MD**

**Patient name** \_\_\_\_\_ **Date of birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the medical problem for today's visit? \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_

What has made this better or worse? \_\_\_\_\_

Is the condition worse at any time of the day or year? \_\_\_\_\_

Are there any other symptoms related to this condition? \_\_\_\_\_

List all current medications: \_\_\_\_\_

List any allergies to medication: \_\_\_\_\_

List any past injuries or accidents: \_\_\_\_\_

List any past surgical procedures: \_\_\_\_\_

List any known inherited conditions in the patient's family: \_\_\_\_\_

List any siblings and their ages: \_\_\_\_\_

List any special physical activities: \_\_\_\_\_

Does the patient have or ever had any of the following medical conditions? (please check yes or no)

YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	ENT Problem other than above
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss or tiredness
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Skin disease (such as rashes)
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (growth problem, diabetes)
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease (e.g. clotting problems)
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems

YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	Muscle or bone problems
<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems
<input type="checkbox"/>	<input type="checkbox"/>	Allergic or immune problems
<input type="checkbox"/>	<input type="checkbox"/>	Breathing problems related to lungs
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or behavioral problems
<input type="checkbox"/>	<input type="checkbox"/>	Urinary or kidney problems

\_\_\_\_ None of the above

If you answered "yes" to any of the above, please describe the condition \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the patient's medical history as outlined above

\_\_\_\_\_ Date: \_\_\_\_\_

Michael Rothschild, MD

# Notice of Privacy Practices

Michael Rothschild, MD  
Jacqueline Jones, MD

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**This Notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully.**

This Notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding such medical information. We are required by law to make sure that medical information which identifies you or your child is kept private, to give you this Notice of our legal duties and privacy practices with respect to your medical information, and follow the terms of the Notice that is currently in effect.

This notice covers the medical practices of Dr. Michael Rothschild and Dr. Jacqueline Jones, and their employed personnel. It is effective as of April 14, 2003.

## Using and Disclosing Medical Information

The following categories describe different ways that we use and disclose medical information.

### Treatment

We may use medical information about you or your child to provide you or your child with medical treatment or services. We may disclose medical information about you or your child to doctors, nurses, technicians, medical students, or other personnel at our affiliated institutions (Weill Cornell, New York-Presbyterian Hospital, Mount Sinai Medical Center, Lenox Hill Hospital, Manhattan Eye and Ear Infirmary, Elmhurst Hospital and Refuah Health Center), who are involved in taking care of you or your child. For example, a doctor treating your child for sinusitis may need to know if he or she has diabetes, because diabetes may affect the treatment. Different departments of the affiliated institutions also may share medical information about you or your child, such as prescriptions, lab work and x-rays, to coordinate your treatment. We also may disclose medical information about you or your child to medical personnel outside the affiliated institutions who may be involved in the medical care of you or your child. Specifically, we will communicate the results of our consultation with your primary care physician, your child's physician (pediatrician) and the physician who referred you or your child to our office.

### Payment

We may use and disclose medical information about you or your child so that we may bill for treatment and services, and so that we can collect payment from you, an

insurance company or another party. For example, we may need to give information about surgery you or your child received or are going to receive to your health plan so that the plan will pay us or reimburse you for the surgery. In the event a bill is overdue, we may need to give information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies. We may also disclose information about you or your child to our Affiliated Institutions and other healthcare facilities for purposes of payment as permitted by law.

### Health Care Operations

We may use and disclose medical information about you or your child for operations of our Affiliated Institutions. These uses and disclosures are necessary to run these institutions and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students, and other medical personnel for educational purposes. We may also disclose information about you or your child to other healthcare facilities as permitted by law.

### Appointment Reminders; Treatment Alternatives; Health-Related Benefits and Services

We may use and disclose medical information to contact you to remind you that you or your child have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options and health-related benefits and services that may be of interest to you.

### Individuals Involved in Your Care or Payment for Your Care

We may release medical information about you or your child to a friend or family member who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition or the condition of your child. If you do not wish us to share this information with such individuals, please follow the procedures described in the Right to Request Restrictions section of this Notice below. In addition, we may disclose medical information about you or your child to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

### Research

All research projects are subject to a special approval process before your medical information may be used or

disclosed. An institutional review board oversees all research involving human subjects, and even chart reviews cannot be undertaken without specific approval of the board. Furthermore, before any patient-specific information (such as a name or contact number) can be used in this manner, you would be contacted for specific written permission. You are not under any obligation to give such permission at any time. Agreeing to this privacy policy does not mean that you are allowing your medical records to be used for any such research purposes.

### **As Required By Law**

We will disclose medical information about you or your child when required to do so by federal, state or local law.

### **Special Privacy Protections**

If your medical information includes HIV-related information, alcohol or substance abuse, mental health or genetic information, special protections may apply to such information. You can contact the Privacy Officer if you have any questions.

### **To Avert a Serious Threat to Health or Safety**

To Avert a Serious Threat to Health or Safety of you, the public or another person, we may use or disclose medical information about you.

### **Organ and Tissue Donation**

If you or your child are an organ or tissue donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

### **Military and Veterans**

If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities.

### **Workers' Compensation**

We may release medical information for workers' compensation or similar programs.

### **Public Health Risks**

We may disclose to authorized public health or government officials medical information about you or your child for public health activities when required or authorized by law. These activities generally include the following: to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or service; to prevent or control disease, injury or disability; to report disease or injury; to report births and deaths; to report reactions to medications and food or problems with products; to notify people of recalls or replacements of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority

if we believe a patient has been the victim of abuse, neglect or domestic violence.

### **Health Oversight Activities**

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

### **Lawsuits and Disputes**

If you or your child are involved in a lawsuit or a dispute, we may disclose medical information about you or your child in response to a court or administrative order. We may also disclose medical information about you or your child in response to a subpoena, discovery request, or other legal demand by someone else involved in the dispute, but only if efforts have been made by us or someone else to tell you about the request or to obtain an order protecting the information requested.

### **Law Enforcement/National Security/Protective Services**

We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on the premises of Weill Cornell; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; to authorized federal officials so they may provide protection for the President and other authorized persons, or conduct special investigations, or for intelligence, counterintelligence, and any other national security activities authorized by law.

### **Coroners, Medical Examiners and Funeral Directors**

We may release medical information about deceased persons to a coroner, medical examiner or funeral director so they can carry out their duties.

### **Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made with your written authorization, on an appropriate authorization form. You may revoke such an authorization by writing to the Privacy Officer, and such revocation will be effective to the extent that we have not already released the information pursuant to the authorization or otherwise taken action in reliance on the authorization.

## **Your rights regarding medical information about you or your child.**

### **Right to Inspect and Copy**

You have the right to inspect and copy medical information that may be used to make decisions about

your care or the care of your child. Usually, this includes medical and billing records. This right does not include: psychotherapy notes; information compiled for use in a legal proceeding; or certain information maintained by laboratories. In order to inspect and copy medical information that may be used to make decisions about you, must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing to the Privacy Officer that the denial be reviewed. A licensed healthcare professional who was not directly involved in the original decision to deny access will conduct the review. We will comply with the outcome of the review.

### **Right to Request Amendments**

If you think that medical information we have about you or your child is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address listed at the end of this Notice. In addition, you must give a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (2) is not part of the medical information maintained in our records, (3) is not part of the information you would be permitted to inspect and copy, or (4) is accurate and complete.

We will provide you with written notice of action we take in response to your request for an amendment.

### **Right to an Accounting of Disclosures**

You have the right to request an "accounting of disclosures." This is a list of certain disclosures we have made of medical information about you or your child. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment, or healthcare operations, made pursuant to an authorization signed by you, or and which fall into certain other limited categories of disclosures. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address listed at the end of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. You may request one accounting in any 12-month period free of charge, and we will charge you for any subsequent request in the same 12-month period. Such charge may include reasonable retrieval, list preparation, and mailing costs.

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on the medical information we use or disclose about you. You

also have the right to request a limit on the medical information we disclose about you or your child to someone who is involved in your care or the payment for your care, such as a family member or friend. If you wish to request such a restriction, you must contact the Privacy Officer in writing at the address listed at the end of this Notice. We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you or your child with emergency treatment.

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must contact the Privacy Officer in writing at the address listed at the end of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

### **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this Notice. You may obtain a copy from our office or by contacting the Privacy Officer. You may also obtain a copy of this Notice electronically through our Web site at [www.KidsENT.com](http://www.KidsENT.com).

### **Changes to this notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you or your child we already have as well as any information we receive in the future. The current Notice in effect at any time will be available from the Privacy Officer as well as at our office.

### **Complaints**

If you believe that your privacy rights or the rights of your child have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please call or write to the Privacy Officer at the address listed at the end of this Notice. You or your child will not be penalized or retaliated against for filing a complaint.

### **Questions**

If you have a question about this notice, please contact:

Privacy Officer  
Park Avenue ENT  
1175 Park Avenue, 1A  
New York, NY 10128  
(212)996-2995

# MICHAEL A. ROTHSCHILD, M.D.

## Acknowledgement of Financial & Privacy Practice Policies

### Dear Patients:

Welcome to our office! Our goal is to provide the highest standard of patient care and it is essential that we establish a clear understanding of our Financial and Privacy Policy with our patients. Should you have questions or concerns about our fees, policy, your financial responsibility or our privacy practices, please do not hesitate to ask.

**IN-NETWORK INSURANCE** - Dr. Rothschild participates in various insurance plans. If Dr. Rothschild is considered "in-network" with your carrier, you are responsible for all co-payments at the time of service. You may also have in-network deductibles and coinsurances for all procedures done at the time of service. Once we receive the EOB from your insurance carrier, we will send one statement for the balance.

**OUT-OF-NETWORK INSURANCE** - We ask for payment in full at the time of service and as a courtesy, we will gladly submit the claim form to your insurance carrier for your reimbursement consideration. Dr. Rothschild's team is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier. Please contact your insurance company directly for details regarding your out-of-net work coverage.

**SELF PAY PATIENTS** - We ask for payment in full at the time of service and will provide you with a receipt for your records.

**REFERRALS** - If your insurance company requires a referral to see a specialist, it is the patient's responsibility to obtain prior to the appointment. Please remember that referrals expire and you are responsible for renewing with your primary care physician or pediatrician. If you are unable to obtain a referral prior to your appointment you are required to pay for the visit at the time of service.

**CANCELLATION POLICY** - We understand that unexpected events occur and we ask that you contact the office as soon as possible to cancel or reschedule your appointment. In the event you do not arrive for your appointment you may be charged a cancellation fee. We ask that you arrive promptly for your appointment, as we want to provide as much undivided attention and care to you and your family. If you are more than 10 minutes late for your appointment, we will consider you a "fit in" patient and will be seen when time allows.

**DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Dr. Rothschild or his staff will not be involved with separation or divorce disputes regarding payment and/or services. If the patient is 18 or over, they will be required to sign an authorization form consenting to disclosing medical/financial information to the parents.

**PAYMENT METHODS** - We accept Visa, MasterCard, American Express, checks and cash.

**DIAGNOSTIC PROCEDURES** - During the process of your evaluation and management by Dr. Michael Rothschild, he may deem it appropriate and necessary to more closely examine your ears, nose, and/or throat using commonly tried and tested methods and in-office mildly invasive diagnostic procedures. Your insurance company may list these codes as surgical in nature even though they are performed in the office. Such procedures can include, but not limited to, Nasal Sinus Endoscopy (31231), Laryngoscopy (31575), Cerumen Removal (69210), and hearing testing. These procedures are the doctor's only tools to be better able to diagnose and treat your medical issues. You will be financially responsible for anything applied to your deductible and/or co-insurance arising from the billing of these codes.

**AGREEMENT** - *I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Michael Rothschild or my insurance company to release any information required to process my claims.*

*I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.*

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How would you like your appointments to be confirmed (Check all that apply):

Home     Cell     Email     Text