225 Broadway, Suite 1610 · New York, NY 10007
715 Park Avenue Suite 2 · New York, NY 10021
Tel 347.557.8368 · **Fax** 646.304.1278
info@enttribeca.com

Name ________________________________ Date of Birth ______________________ Age _________ Gender_______
First + Last Month/Date/Year

Address ____ City ___________________ State _________ Zip ___________

Phone ___________________________ Alternate Phone __________________________ Height ______ Weight ______

Email Address ____ Occupation ______________________________________

Emergency Contact ____
Name Relationship Phone

Primary Care Physician ____________________________________ Phone _______________________________________

*Email/Klara is our preferred method of communication for appointment confirmations, test results, prescriptions/refills and billing matters. Please initial here ________ to indicate that you are willing to receive email/Klara correspondence related to your care from the practice.

How did you find Dr. Reitzen?

[ ] Physician Referral (please provide name) ____

[ ] Family/Friend Referral (please provide name) ____

[ ] Other (please describe) ____

Insurance information:

Primary Insurance Company __________________________________ Plan __________________________________

Policy Number ____Group __________________________________

In compliance with new healthcare regulations, we send prescriptions electronically. Please provide us with your pharmacy information below. If you do not have a pharmacy of record, we can either recommend one for you or help you find one that is convenient.

Pharmacy __________________________ Location _________________________________ Phone _______________________

I affirm that the above information is accurate and up to date:

Patient Name (print) ____________________________ Signature ____________________________ Date _______________

SHARI REITZEN, MD
FACIAL PLASTIC SURGERY

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MEDICAL HISTORY

Please circle all that apply:

Heart Disease or Arrhythmia	Diabetes	Peptic Ulcer Disease
Artificial Heart Valve	Thyroid Disease	Neurologic Disease
Heart Murmur	Cancer	Lung Disease/Asthma
Pacemaker or ICD	Arthritis or Rheumatologic Disease	Kidney Disease
Bleeding Problems	Bell's Palsy	Liver Disease/Hepatitis
Hypertension (High Blood Pressure)	Major Skin Infections or MRSA	Depression/Anxiety
High Cholesterol	Immune Deficiency/HIV	Keloid Formation

Do you smoke? _________ Packs per day/week _________ Do you drink alcohol? _________ Drinks per day/week _________

Female patients – Are you pregnant? ______________

Have you had previous surgeries/procedures or any associated complications? ____

If you had anesthesia, were there any issues or side effects? ____

List any other medical problems and provide additional information for "yes" answers: ______________________________

____

MEDICATIONS

Please list:

1. ______________________ 7. ______________________
2. ______________________ 8. ______________________
3. ______________________ 9. ______________________
4. ______________________ 10. ______________________
5. ______________________ 11. ______________________
6. ______________________ 12. ______________________

Any allergies to medications?
Please list below (include reaction).

____

____

____

____

DERMATOLOGIC/COSMETIC HISTORY

1. Do you have a family history of skin cancer? Yes No If yes, who and what type? ____________________________
2. Have you ever had a biopsy for a suspicious growth? Yes No
3. What is the primary reason for your visit? ____

____

____

Patient Name (print) ______________________________ Signature ______________________________ Date ________________

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HIPAA PRIVACY POLICY

I hereby give my consent for NS Medical, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. NS Medical, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NS Medical, PLLC at the above address.

With this consent, NS Medical, PLLC, may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care as long as it is marked Personal and Confidential.

With this consent, NS Medical, PLLC, may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and material pertaining to my clinical care. I have the right to request that NS Medical, PLLC restrict how it uses or discloses by PHI to carry out my TPO.

NS Medical, PLLC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to NS Medical's use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NS Medical, PLLC, may decline to provide treatment to me.

Patient Name (print) ___________________________ Signature ________________________ Date _________________

CONSENT FOR PROCEDURES

Please be aware that some procedures performed in this office are billed as a separate charge to your insurance. This is IN ADDITION to the charge for the office visit. **There may be additional fees from your insurance company related to these procedures.**

Some of the procedures may include, but are not limited to:

1. **Nasal endoscopy: a lighted camera to look at your sinuses and the back of your nose ($100-250)**
2. **Fiberoptic laryngoscopy: a lighted camera to look at your throat and vocal cords ($100-250)**

-- PLEASE BE INFORMED THAT ONE OF THE ABOVE PROCEDURES IS PERFORMED WITH MOST OFFICE VISITS. IF YOUR PLAN APPLIES A DEDUCTIBLE OR SEPARATE CHARGES FOR PROCEDURES, YOU WILL LIKELY BE RESPONSIBLE FOR PAYING THE ABOVE AMOUNT.

3. Earwax removal ($40-100)
4. Excision of lesions/masses ($200-1000 depending on size/situation)

I have carefully read this consent and understand its content, and I have had the opportunity to ask any questions that I have.

If we are participating providers:
We will submit bills directly to your insurance company for payment on your behalf. It is important you understand your plan in terms of Copays, Deductibles & Coinsurance.

If we are non-participating providers:
If we are non-participating with your insurance company, full payment is due at time of service. It is the responsibility of the patient to submit reimbursement directly to the insurance company.

By signing below, I indicate that I agree to the procedure.

Patient Name (print) ___________________________ Signature ________________________ Date _________________

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Credit Card Authorization Form

In our efforts to go green and keep the cost of healthcare down, we have implemented the following policy:

If we are in-network and participating providers with your insurance company, you will be asked for a credit card number at the time of your check in. This information will be held securely in your file and the card will be charged for your financial responsibility once the claim has processed. **It is in your best interest and your responsibility to understand your insurance plan.**

If your insurance company rejects the claim due to eligibility, medical necessity and the terms, conditions, limitations and exclusions of the health benefit plan at the time services are rendered, we will charge your card our adjusted self-pay rates.

We have enforced a 24 hour cancellation policy. Failure to provide notice of procedure cancellations without giving enough notice would result in a $100 cancellation fee.

Please note that this policy does not compromise your ability to dispute a charge or question your insurance company's processing of a claim or determination of patient responsibility. For any charges over $100, you will receive a courtesy notification via our patient portal Klara or by phone that your card will be charged for any outstanding balance.

I authorize Tribeca ENT & Facial Plastic Surgery to charge outstanding balances on my account to the following credit card:

VISA	MASTERCARD	AMERICAN EXPRESS	DISCOVER

Credit Card Number:

Expiration Date:

Security Code:

Billing Zip Code:

Name on Card: ____

Patient Name: ________________________ Signature: __________________________Date: _______________

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Authorization for Release and Use of Photographs

The undersigned, ____, is a patient of Shari D Reitzen, MD, ("the treating physician") and has been or will be photographed during the course of treatment. (By the term "photographs," this form also includes digital images.) Those photographs will become part of the medical record in the patient chart. Under the Health Insurance Portability and Accounting Act of 1996 (HIPAA), those photographs may be supplied as part of the medical records to medical specialty boards and hospital medical staffs reviewing the treating physician's credentials under a "Business Associate Contract" prescribed by HIPAA. In addition, the undersigned grants to the treating physician the on-going and unrestricted right to use those photographs (but not the patient's name) in the following way **(please check all applicable):**

______ Use by medical specialty board in formulating its examination of applicant Physicians
______ Medical research, education, or science
______ Professional medical journals, videos, or books
______ Patient education purposes, including the treating physician's procedural and general information brochures and photo book for prospective patient viewing
______ Slides, computer images, website and televisions media providing information about physician's practice to the interested public (including public relations)

The undersigned acknowledges that the persons to whom the photographs may be disclosed for above stated purposes include other practicing physicians, medical students, health care providers, credentialing organizations (such as the American Board of Facial Plastic and Reconstructive Surgery), and their staffs. Prospective patients and the public may, under some of the above alternatives, also view the photographs. Under HIPAA, if the organization or person authorized to receive the photographs is not a health plan or health care provider, the released information may not be covered by HIPAA's protections from further disclosures or use by federal privacy regulations.

This authorization may only be revoked in writing, signed by the undersigned and delivered to the physician at treating physician's address below. Such revocation shall thereafter be effective as to any further use not already committed to by the physician. Unless earlier revoked, this authorization will expire on the end of the treating physician's practice of facial and reconstructive surgery, except there will be no expiration for the purpose of medical or scientific research or use in specialty-board examinations. Revocation will not affect uses and disclosures made before receipt of the revocation. This authorization is in consideration of services performed and consultations conducted or to be performed or conducted by the physician, and there have been no representations or inducements concerning this authorization except as set forth herein. The treating physician will not condition treatment on whether the individual signs this authorization. The undersigned may see and copy any photographs described on this form upon request and may receive a photocopy of this Authorization form upon request.

Signed (Patient or Authorized Parent/Guardian): ______________________________ Date: ________________