PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/_____ Sex: ☐ Male ☐ Female SS#:____-___-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Race/Nationality: _____ Language: _____

Home Address: _____ Apt#: _____ City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____ E-mail: _____

Employer: _____ Phone: _____ Occupation: _____

***Emergency Contact Name*:** _____ *Phone*: _____ *Relationship*: _____

PRIMARY INSURANCE

Insurance Name: _____ Policy ID: _____ Group Number: _____

Name of Primary Insured: _____ Date of Birth: ____/____/_____ Relationship: _____

SECONDARY INSURANCE

Insurance Name: _____ Policy ID: _____ Group Number: _____

Name of Primary Insured: _____ Date of Birth: ____/____/_____ Relationship: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____ Phone: _____

PHYSICIANS AND SPEECH LANGUAGE PATHOLOGISTS LISTED BELOW WILL BE CC'D ON YOUR VISIT REPORTS:

PHYSICIAN: _____

Specialty: _____

Address: _____

_____

Phone: _____ **Fax:** _____

PHYSICIAN: _____

Specialty: _____

Address: _____

_____

Phone: _____ **Fax:** _____

☐ **SELF: I would like to receive my visit reports** via our Patient Portal (or mailed to my home address).

ASSIGNMENT OF BENEFITS

CLAIMS AUTHORIZATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR ALL PATIENTS

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claims submitted to any health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan; self-insurer or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is a group contract held by my employer, an association, trust fund, union or similar entity, this authorization shall become effective immediately, remain upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until claim reaches final consummation. This authorization shall be binding upon my dependents, and my heirs, executors, administrators and me. **ADDITIONAL AUTHORIZATION FOR MEDICARE POLICYHOLDERS-** I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize my holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

— ***I have read the above agreement and authorize payment of medical and surgical benefits to be made on my behalf to my physician(s) in this office. I also understand that I am responsible for any balance remaining after all insurance coverage(s) has been secured.***

Signature of Patient / Representative: _____ Date: _____

THE NOTICE OF PRIVACY PRACTICES (NOPP)

I acknowledge that I have read the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Signature of Patient /Representative: _____ Date: _____

**PATIENT REFUSED : _____-___/___/_____

APPOINTMENT REMINDERS

I agree that our automated calling service can call my home and/or cell phone to confirm my appointment, including leaving a message on an answering machine, voicemail service or a person when I am unable to answer.

Signature of Patient /Representative: _____ Date: _____

PATIENT HISTORY

Name: _____ Date of Birth: ____/____/_____ Today's Date: ____/____/_____

Description of problem: _____

How long have you had the current problem? _____

1. What is your reason for your visit?

☐Diagnosis and management of voice issue ☐Second opinion ☐Other _____

2. Do you have or have you ever had any of following medical conditions? **Please mark either yes (Y) or no (N)**

Y / N		Y / N		Y / N	
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Swallowing Difficulty
☐	☐ Asthma	☐	☐ High Blood Pressure	☐	☐ Thyroid Disease
☐	☐ Chronic Sinus Infection	☐	☐ H.I.V. / AIDS	☐	☐ **Cancer – list type and date of diagnosis:**
☐	☐ Diabetes	☐	☐ Kidney Disease		_____
☐	☐ Hand Tremor	☐	☐ Seizure/Neurological Disease		_____
☐	☐ Hearing Loss	☐	☐ Shortness of Breath		_____
☐	☐ Heart Disease	☐	☐ Stomach Ulcers		_____

	Y / N	
3. Have you had any previous surgery?	☐ ☐	**If yes, please list**: _____ _____
4. Family history of any medical conditions?	☐ ☐	**If yes, please list**: _____
5. Do you have any environmental allergies?	☐ ☐	**If yes, please list**: _____
6. Do you have any allergies to medications?	☐ ☐	**If yes, please list**: _____
7. Are you taking any medications, including over-the-counter medications?	☐ ☐	**If yes, please list**: _____ _____ _____
8. Do you or did you ever smoke?	☐ ☐	**If yes, how much?** _____ **Have you quit? If so, when?** _____
9. Do you drink alcohol?	☐ ☐	**If yes, how much?** _____

10. How much caffeine do you drink? _____ 11. Height _____ 12. Weight _____

13. **IN WHAT CAPACITY DO YOU USE YOUR VOICE?**

☐Singer/Cantor ☐Actor ☐Event Host/MC ☐Teacher ☐Sales ☐Politician ☐Attorney ☐Clergy ☐Fitness instructor
☐Regular everyday use ☐Other (please specify): _____

14. Have you ever had any of the following symptoms? **Please mark either yes (Y) or no (N)**

Y / N		Y / N		
☐	☐ Hoarseness (rough or scratchy voice)	☐	☐ Frequent heartburn	Other: _____
☐	☐ Frequent sore throat	☐	☐ Frequent throat clearing	_____
☐	☐ Vocal fatigue	☐	☐ Pain while speaking	
☐	☐ Tickling or choking sensation	☐	☐ Voice worse in the morning	

* For Singers:	Y / N	* For Women:	Y / N
	☐ ☐ Prolonged warm up time (over ½ hour)		☐ ☐ Are you pregnant?
	☐ ☐ Loss of range (high or low)		☐ ☐ Are your menstruation cycles regular?
	☐ ☐ Volume disturbance		☐ ☐ Have you undergone hysterectomy?

FOR OFFICE USE ONLY

Physician's signature _____ Date _____

PEAK WOO, MD, FACS
300 Central Park West, 1-H • New York, NY 10024 • (212)580-1004 • (212)580-6101 (FAX)

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of the terms of your insurance and of our Financial Agreement is important to our professional relationship. While we verify your coverage, it is not a guarantee of coverage for services rendered. You are bound by the terms of the claim settlement. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS-** If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be personally responsible for that day's services.
- **CO-PAYMENTS-** By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **IN or OUT OF NETWORK –** You will be responsible for any balance your plan indicates as due on its explanation of benefits form. We will adjust the charges to coincide with your plan's explanation of benefits. All patients will be responsible for their co-insurance and deductible.

  If we do not "participate" with your plan, payment will be expected at the time of service unless prior arrangements have been made with our financial staff. We will send a courtesy bill to that carrier on your behalf and balance bill you.
- **SELF-PAY PATIENTS-** Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE-** We will submit claims to Medicare and to your secondary carrier if you have one. You will be responsible for the deductible, the 20% co-insurance and any uncovered costs agreed to on the ABN.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Dr. Peak Woo for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCE/SEPARATED PARENTS OF MINOR PATIENTS-** The guarantor is responsible for payment of services rendered. Dr. Woo cannot be involved with the separation of divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to complete the payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept **CASH, CHECKS, MASTERCARD, VISA OR AMERICAN EXPRESS CARDS.**

Thank you for understanding our policies. Please feel free to ask any questions or share any special concerns.

I have read and agree to the above statement.

Signature of Patient /Representative: _____ Date of Birth: _____/_____/_____

Print Name: _____ Date: _____

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