Patient Intake

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Patient Information (Please Print) Date:______________________

Name(Last, First, MI): ____ Age: _______

Gender: ________ Date of Birth: ___________________ Marital Status: __Single __Married ___Divorced __Widowed

Address: ____ Apt#: ______________

City: ____ State: ________________ Zip Code: _________________

Primary Phone#: ________________________________ Secondary Phone#: _______________________________

Work Phone: ___________________________________ Social Security#: __________________________________

Email Address: ____

Mother's Name: _________________________________ Father's Name: ____________________________________

Emergency Contact: ____ Relation: ________________________

Primary Phone#: ________________________________ Secondary Phone#: _______________________________

Billing

Name: __________________________________ Relation to Patient: ______________ Date of Birth: ______________

Address: ____

City: ____ State: ________________ Zip Code: _________________

Occupation: ______________________________________ Employer: _______________________________________

Primary Phone#: ________________________________ Secondary Phone#: _______________________________

Insurance Information (Please alert receptionist if workers comp or a no-fault case)

Primary Ins: ______________________________________ Ins Phone: ______________________________________

Primary Ins Address: ____

Subscriber: ______________________________________ Relation to Patient: ___ Self ___ Spouse ___Child ___ Other

Insurance ID#: ___________________________________ Insurance Group#: ___________________________________

Secondary Ins: ___________________________________ Ins Phone: _______________________________________

Secondary Ins Address: ____

Subscriber: ______________________________________ Relation to Patient: ___ Self ___ Spouse ___Child ___ Other

Secondary Insurance ID#: ____________________________ Insurance Group#: ___________________________________

Patient Intake Form

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Patient Name:____________________________________ Date of Birth:_____________________

Past Medical History	
□ High blood pressure	□ COPD
□ Diabetes	□ Thyroid disease
□ Heart disease	□ Seizures
□ Stroke	□ Anxiety
□ Asthma	□ Depression
□ Other:	

Referring MD Name:	Primary Care MD □ Same Name:	Pharmacy Preference Name:
Phone:	Phone:	Phone:
Address	Address	Address:

Operations
1.
2.
3.

Allergies
1.
2.
3.

Reasons for Visit:			Height:	Weight:
Do you drink alcohol?	□No, never	□No, but used to	□Yes How many drinks? _____day/week	
Do you smoke?	□No, never	□No, but quit________	□Yes Packs per day ____x____years	
Illicit drug use?	□No, never	□No, but used to	□Yes Which drug?_________________	

Do you currently have any of the following problems?					
Constitutional		Respiratory		Immunologic/Allergy	
Weight gain/loss	□Y N□	Shortness of breath	□Y N□	Seasonal allergies	□Y N□
Fevers	□Y N□	Cough	□Y N□	Autoimmune problems	□Y N□
Ear/Nose/Throat		Cardiovascular		Musculoskeletal	
Hearing Loss	□Y N□	Heart murmur	□Y N□	Arthritis	□Y N□
Ear Pain	□Y N□	Gastrointestinal		Neurologic	
Ringing in the ears	□Y N□	Heartburn	□Y N□	Headaches	□Y N□
Runny nose	□Y N□	Diarrhea	□Y N□	Leg/arm weakness	□Y N□
Nasal bleeding	□Y N□	Constipation	□Y N□	Balance problems	□Y N□
Nasal congestion	□Y N□	Nausea/vomiting	□Y N□	Hematology	
Facial pain/pressure	□Y N□	Genitourinary		Easy bruising	□Y N□
Jaw pain	□Y N□	Frequent urination	□Y N□	Anemia	□Y N□
Sore throat	□Y N□	Urinary incontinence	□Y N□	Eyes	
Voice changes	□Y N□	Skin		Vision changes	□Y N□
Enlarged lymph nodes	□Y N□	Rash/moles	□Y N□	Glaucoma	□Y N□

Family History	Mother	Father	M.G. Mother	M.G. Father	P.G. Mother	P.G. Father
Heart Disease						
Cancer						
Bleeding Disorders						
Diabetes						
Thyroid Disease						
Stroke						

The above information is accurate to the best of my knowledge.

____

Signature of Parent of Guardian Print Name Date

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Referring Physician, Medication and Pharmacy Information Form

Patient's Name:	Date:
Name and Address of Internist of Referring Doctor:	
Physician's Name:	
Address:	
Telephone:	Fax:

Medications

Do you have any allergies to medications? ☐ No ☐ Yes (Please List):

Please list all medications that you are taking (including over-the-counter medication, such as eye drops, aspirin, Motrin, nasal sprays, vitamins, herbal remedies, birth control pill, etc.)

Medications	Dosage (mg, teaspoon, etc.)	Frequency

Vaccination History

Date of most recent Flu Shot (ages 6 mos+)	Date of most recent Pneumonia shot (ages 65+)

Privacy 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:	

Sino-Nasal Outcome Test-22 Questionnaire v4

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate you answering the following question to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems, as they have been over the past two weeks. Thank you for your participation.

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how 'bad' it is by circling the number that corresponds with how you feel using this scale.	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain/pressure	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Waking up at night	0	1	2	3	4	5
13. Lack of a good night's sleep	0	1	2	3	4	5
14. Waking up tired	0	1	2	3	4	5
15. Fatigue during the day	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5
21. Sense of taste/smell	0	1	2	3	4	5
22. Blockage/congestion of nose	0	1	2	3	4	5
Total						
					Grand Total	

For Medical Use Only:

Patient No.: D.O.B.: Date
M F

Diagnosis: Aims of Treatment:

Today's treatment: L-M score:

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

How did you hear about us?

○ Family
○ Friend
○ US News and World Report
○ NewYork-Presbyterian Hospital
○ Weill Cornell
○ Sinusitis-Solutions.com
○ Physician:____
○ Other:____

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Acknowledgement

I, the undersigned, acknowledge that I have received the following disclosures of the practice:

- Facility Information
- Facility Ownership Disclosure
- Patient Bill of Rights
- Health Practice and Privacy Act Information
- Compliant Resolution Policy
- Billing Information/ Out-of-Network Insurance Status (does not apply to 1199 insurance)
- Physician Qualifications

Patient Name: ____
(Print)

Signature: ____ **Date:** _____________________
(Patient or Responsible Party)

Reviewed by Dr. Vijay Anand: ____

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Payment Policy for In-Office Procedures

In addition to an office visit, consultation and examination, your care may also involve office procedures that are routinely performed in the evaluation of Ear, Nose and Throat conditions. As per customary practice with medical insurance carriers, these office procedures are billed as a distinct procedure from the office visit. Your health plan may categorize these procedures as **surgical** and apply the fees for these services to you as a copay, co-insurance, deductible and/or out-of-pocket charge. This is based on your contract with your insurance carrier.

These procedures include, but are not limited to, the following:

○ **Nasal Endoscopy: Examination of the nasal and paranasal sinus cavities with a fiberoptic endoscope.**

○ **Nasal Endoscopy with debridement or biopsy: Includes a nasal endoscopy and additionally includes removal of crusting or tissue.**

○ **Flexible Laryngoscopy: Examination of the throat with a fiberoptic endoscope.**

○ **Cerumen removal: Removal of wax from the ear canals.**

By signing this form, you acknowledge that you are aware of this policy and understand that you are responsible for any of the associated fees.

Patient Name:____
(Print)

Signature:____ **Date:**______________________
(Patient or Responsible Party)

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

Patient Name:______________________________ Date:_________________

Office Financial Policy

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 Policy with our patients. Should you have questions or concerns about our fees, policy, or your financial responsibility, please do not hesitate to ask.

This is your acknowledgment that Dr. Anand does not accept insurance carriers, and you are financially responsible for any balance.

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 reimbursement consideration on your behalf. Please contact your insurance company directly for details regarding your out-of-network coverage. Other circumstances will be handled on a case by case basis.

I understand that my out-of-network insurance deductible must be collected by law.

I am responsible of any co-insurance balance based on my out-of-network benefits after insurance payment.

Assignment of Benefits
I request the payment of authorized insurance carrier benefits to be made on my behalf to Dr. Vijay Anand, M.D., P.C., for any services rendered to me. I authorize the release of any medical information to my insurance carrier or the Health Care Financing Administration and its agents for the purpose of determining benefits payable for related services. Furthermore, I understand that the annual deductible amounts and all co-insurance amounts are my responsibility. If I have assigned my medical benefits to any other party (managed care plans we do not participate in), rendering this office ineligible for payment, I understand that I will be responsible for the entire bill of services. I also acknowledge that Dr. Vijay Anand, M.D., P.C. is not financially responsible to reimburse me or any other party for any services not covered by outside providers which I may have been referred to. I have received the notice of privacy practices, and I have had an opportunity to review it and ask questions.

____

Signature of Patient or Responsible Party

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660
Email: vijayanandmd@gmail.com
Sinusitis-solutions.com
Endoscopicskullbasesurgery.com

Dear Patients,
Our physician and staff at Vijay Anand M.D., P.C., and East Side Physician Specialist, would like to take this opportunity to welcome you to our office. As your providers of health care, we look forward to serving you. We hope that, together, we can build the kind of relationship that will ensure that you receive quality care and good service.

In order to maximize your health benefits, it is very important that you familiarize yourself with the systems, policies, and protocols outlined in this letter or ask our courteous staff if you have any further questions.

The following is important information you should know:

SCHEDULING APPOINTMENTS:
Our appointment desk is available Monday through Friday, from 9am to 5pm daily, 212-452-3005. After office hours, you may call this number and a recording will provide emergency information. Our fax number is 212-452-3660.
Parking garages- 73rd street between 3rd Avenue and Lexington Avenue.

CANCELLATIONS:
If you must cancel and appointment, please call the appointment desk AS SOON AS POSSIBLE.

YOU HAVE CERTAIN PATIENT RIGHTS:

1. You have the right to be treated with respect, consideration, and dignity.
2. You have the right to high quality medical care delivered in a safe, timely, efficient and cost effective manner, and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the fullest extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment, and prognosis.
6. You have the right to the copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages, disadvantages and alternatives to having the procedure performed in the office or other outpatient facility or hospital.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives discussed in #7 above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
12. You have the right to know the available services at the facility.

13. You have the right to know the provisions for after hours and emergency care.
14. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
15. You have the right to know whether or not your providers are insured.
16. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals in the event that you are dissatisfied with your treatment.
17. You have the right to know the name of your provider.
18. You have the right to know what fees are expected and what the payment policies are.
19. You have the right to know what the physician's credentials are.
20. You have the right to change providers at any time.

YOU ALSO HAVE CERTAIN RESPONSIBILITIES:

1. You have the responsibility to accurately and completely provide all clinical personnel with the health information they need, including any medications you are taking.
2. You have the responsibility to follow directions given by the medical assistant or physician with regard to diet and/or medication. Compliance is important for desired medical results.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you, and that you have not revealed to the medical assistant or physician.
4. You have the responsibility to abstain from alcohol as directed by your medical assistant or physician.
5. You have the responsibility to inform the medical assistant or physician if you do not understand any directions, or you do not understand the course of treatment planned for you.
6. You have the responsibility to timely pay all medical bills that are not in dispute, and to forward to us any money you receive for our services from direct insurance company reimbursement, along with a copy of the explanation of benefits.

COMPLAINT RESOLUTION:

We at East Side Physician Specialist strive to provide you with excellent quality care. We strongly believe in changes to improve, and welcome any opportunity to listen to your suggestions and complaints. Please contact office administrator, Ms. Shoni Thoulouis, regarding any issues, or to get further information about our complaint resolution policy.
Our office is accredited with, and follows strict guidelines and standards required by the **Joint Commission**, a governing body that ensures quality and safety at medical facilities. If you have any unresolved issues and complaints, you can contact the Joint Commission directly:

Email: complaint@jcaho.org
Mail: Office of Quality Monitoring
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Telephone: 800-994-6610

Our JCAHO site name is East Side Physician Specialist
Our JCAHO reference number is 431904

BILLING AND PAYMENT:
Please see our front desk medical biller for details regarding consultation and/or other fees.

INVOLVED IN YOUR HEALTHCARE:
Everyone has a role in making healthcare safe. Our physician, medical assistant, surgical coordinator, and office administrator are working to keep your healthcare safety an ultimate priority. You as a patient can play a vital role in keeping your care safe by becoming an active, involved, and informed member of the healthcare team. So please, SPEAK UP:
S-Speak up if you have any questions or concerns, and if you do not understand, please ask again.
P-Pay attention to the care you are receiving. Make sure you are getting the right treatment and medication.
E-Educate yourself about your diagnosis and treatment plan.
A-Ask a trusted family member to be your advocate.
K-Know what medications you take and why you take them. Keep a list with you.
U-Use an accredited health facility that provides quality care.
P-Participate in all discussions and decisions about your treatment.

PHYSICIAN INFORMATION:
Dr. Anand is Board Certified in Otolaryngology and Head & Neck Surgery.
Becoming a licensed, board certified physician means meeting the most rigorous training and continuing education in the field of medicine.
Certification of Physicians in done by Medical Specialty Boards, recognized by the American Board of Specialties (ABMS) and the American Medical Association (AMA), as a way to inform consumers that the doctors with these credentials have successfully completed approved training, passes an evaluation process assessing their abilities, and completed required continuing medical education credits yearly. Board certification is time-limited, and to maintain their certification, doctors are periodically reevaluated. They must present evidence of licensure and scope of their practice and pass an examination every 7 to 10 years, depending on their specialty.

FACILITY OWNERSHIP DISCLOSURE:

Vijay Anand, M.D., P.C. and East Side Physician Specialist are owned and operated by Dr. Vijay K. Anand.

Please keep this letter for future reference. Should you have any questions, please feel free to contact us. We look forward to serving you.

Sincerely,

Dr. Vijay K. Anand
CEO/ Medical Director