# MICHAEL SETZEN, MD, FACS, FAAP

600 Northern Blvd., Suite 312, Great Neck, NY 11021 • 516.829.0045 • fax: 516.829.0441 • www.michaelsetzen.com


## PATIENT DEMOGRAPHIC FORM

**PATIENT INFORMATION** **DATE:**

Patient Name: _____ Patient's Social Security Number: _____

Date of Birth: _____ Sex: M ○ F ○ Marital Status? S ○ M ○ D ○ W ○ Language: _____ Race: _____

Dominant Hand: Right Hand _____ Left Hand _____ Ambidextrious _____

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell/Pager Number: (_____) _____ Email Address: _____

Emergency Contact Name/Relation: _____ Emergency Contact Phone: (_____) _____

Indicate: ○ Cell ○ Home

**GUARANTOR/PARENT INFORMATION**

Responsible Party Name: _____ _____ _____

(Last) (First) (Middle)

Relationship to Patient: _____ Responsible Party Date of Birth: _____

Guarantor's Social Security Number: _____ - _____ - _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell/Pager Number: (_____) _____

Employer's Name: _____ Work Phone: (_____) _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

**PATIENT's INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to receptionist**

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

**PATIENT's REFERRAL INFORMATION**

Primary Care Physician: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

**Pharmacy:** Name: _____ Phone: _____

Address: _____ Fax: _____

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## MEDICAL INFORMATION SHEET

**PLEASE PRINT CLEARLY**

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Height: _____ Weight: _____ Gender: _____ BP: _____ Pulse: _____

Main Complaint: _____

History of Main Complaint-Describe: _____

ALL MEDICATIONS You Are Taking:

☐ NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

| Medical History: | | | Yes | No |
|---|---|---|---|---|
| Heart: | High Blood Pressure | | ☐ | ☐ |
| | Arrhythmia | | ☐ | ☐ |
| | Heart Attack | | ☐ | ☐ |
| | Angina | | ☐ | ☐ |
| Respiratory: | Asthma | | ☐ | ☐ |
| | Shortness of Breath | | ☐ | ☐ |
| | Sleep Apnea | | ☐ | ☐ |
| Neurology: | Headaches | | ☐ | ☐ |
| | Migraines | | ☐ | ☐ |
| Endocrine: | Thyroid Problems | Hyper | ☐ | ☐ |
| | | Hypo | ☐ | ☐ |
| | Diabetes | | ☐ | ☐ |
| Eyes: | Decreased Vision | | ☐ | ☐ |
| | What: _____ | | ☐ | ☐ |
| Kidney: | What: _____ | | ☐ | ☐ |
| GI Disease: | Reflux | | ☐ | ☐ |
| | Swallowing Problems | | ☐ | ☐ |
| | Weight Loss | | ☐ | ☐ |
| Cancer History: | | | | |
| | What: _____ | | ☐ | ☐ |
| | When: _____ | | | |
| | Treatment: _____ | | | |
| Skin Disease: | | | | |
| | What: _____ | | | |
| Infectious Disease: | Hepatitis | | ☐ | ☐ |
| Musculoskeletal: | Arthritis | | ☐ | ☐ |
| Hematologic: | Bleeding Disorder | | ☐ | ☐ |

Surgical History: Type of Operation

_____

_____

_____

| Social History: | Yes | No |
|---|---|---|
| Do you smoke? | ☐ | ☐ |
| #/Packs a day _____ | | |
| Did you quit? When_____ | ☐ | ☐ |
| Do you drink Alcohol? | ☐ | ☐ |
| # of drinks a day _____ | | |
| Did you quit? When_____ | ☐ | ☐ |
| Are you pregnant? | ☐ | ☐ |

| Family Medical History/Relationship: | | |
|---|---|---|
| Cancer | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Heart Problems | ☐ | ☐ |
| Bleeding Problem | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Seizures/Epilepsy | ☐ | ☐ |
| Asthma | ☐ | ☐ |

| Seasonal Allergies | | Reaction |
|---|---|---|
| Pollens | ☐ | _____ |
| Grasses | ☐ | _____ |
| Trees | ☐ | _____ |
| Cats or Dogs | ☐ | _____ |
| Dust | ☐ | _____ |
| Allergy to Medications | ☐ | _____ |

What Drugs: _____

_____

_____

_____

_____

_____

Latex Allergy ☐

Food Allergy ☐ _____

Patient/Guardian Signature: _____ Date: _____

MICHAEL SETZEN, MD, FACS, FAAP

Nasal & Sinus Surgery • Facial Plastics-Rhinoplasty/Botox/Fillers
Pediatric ENT • Snoring/Sleep Apnea • Reflux/Swallowing/Voice • Laser
Hearing & Balance • Head & Neck • FEESST/Stroboscopy • In-office CT

I authorize my pharmacy _____

Pharmacy Name

_____

Pharmacy Address

to provide my medication list to MICHAEL SETZEN, OTOLARYNGOLOGY, PC

_____

Patient Signature or Authorized Representative Signature

Michael Setzen Otolaryngology, PC
600 Northern Blvd, Suite 312, Great Neck, NY, 11021 • 516.829.0045 • fax: 516.829.0441 • www.michaelsetzen.com
An ICACTL Accredited Facility for CT Imaging

President Elect, American Rhinologic Society
Member, Board of Directors of the American Academy of Ototaryngology — Head and Neck Surgery
Clinical Associate Professor of Otolaryngology, NYU School of Medicine

Adjunct Clinical Assistant Professor of Otolaryngology, Weill Cornell Medical College
Clinical Assistant Professor of Otolaryngology, NY Medical College
Chief Rhinology Section — North Shore University Hospital at Manhassett, NY

Coordinator for Practice Affairs — American Academy of Otolaryngology, HNS
Attending:
St. Francis Hospital, Roslyn, NY
NY Eye and Ear Infirmary, New York, NY
Day-Op Center of Long Island, Mineola, NY
North Shore University at Manhasset, NY

MICHAEL SETZEN, MD, FACS, FAAP

## RECEIPT OF NOTICE OF PRIVACY PRACTICES
## WRITTEN ACKNOWLEDGEMENT FORM

I, , have read a copy of Michael Setzen Otolaryngology, P.C. Notice of Privacy Practices.

Signature of Patient Date

I hereby authorize you to notify/discuss my medical condition with the following:

PMD

Family Member

Family Member

Family Member

# SIGNATURE On FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

NAME (PRINT) _____ MEDICARE NUMBER (if applicable) _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to MSO (herein referred to as MSO) for services furnished me by MSO. I authorize any holder of medical Information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 Form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. MSO accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to PENTA, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** MSO may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to MSO for reimbursement for services rendered, and (2) any health care provider for continued patient care. MSO may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that MSO maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that MSO has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by MSO if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that MSO's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with MSO to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by MSO, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to MSO for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to MSO. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to MSO. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

**********

_____ **Date:** _____

**Beneficiary Signature or Authorized Party**

***SLEEP DISORDER SYMPTOMS ASSESSMENT***

***NAME:***_____

| | | |
|---|---|---|
| ***1.*** *Do you snore on most nights (more than 3 times/week?* | *Yes* | *No* |
| *2. Do you or have you been told, that you stop breathing while sleeping?* | *Yes* | *No* |
| *3. Do you wake suddenly during the night?* | *Yes* | *No* |
| *4. Do you suddenly wake up gasping for air?* | *Yes* | *No* |
| *5. Do you wake up in the morning feeling tired?* | *Yes* | *No* |
| *6. Do you wake up in the morning with a headache?* | *Yes* | *No* |
| ***Please check any of the following you have:*** | | |
| *High Blood Pressure* | *Yes* | *No* |
| *Heart Disease* | *Yes* | *No* |
| *Stroke* | *Yes* | *No* |
| *Insomnia* | *Yes* | *No* |
| *Frequent Urination at night (Nocturia)* | *Yes* | *No* |
| *Diabetes* | *Yes* | *No* |
| *Depression* | *Yes* | *No* |
| *Overweight* | *Yes* | *No* |

*Are you currently using a CPAP? Yes/No, If yes, for how long?*_____

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516-829-0045

NAME: _____

## SINO-NASAL OUTCOME TEST (SNOT-22)

DATE: _____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions 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. Do not hesitate to ask for assistance if necessary.

| 1. Considering how severe the problem is when you experience it and how often 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 | | 5 Most Important Items |
|---|---|---|---|---|---|---|---|---|
| **1. Need to blow nose** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **2. Nasal Blockage** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **3. Sneezing** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **4. Runny nose** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **5. Cough** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **6. Post-nasal discharge** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **7. Thick nasal discharge** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **8. Ear fullness** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **9. Dizziness** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **10. Ear pain** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **11. Facial pain/pressure** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **12. Decreased Sense of Smell/Taste** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **13. Difficulty falling asleep** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **14. Wake up at night** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **15. Lack of a good night's sleep** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **16. Wake up tired** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **17. Fatigue** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **18. Reduced productivity** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **19. Reduced concentration** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **20. Frustrated/restless/irritable** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **21. Sad** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |
| **22. Embarrassed** | 0 | 1 | 2 | 3 | 4 | 5 | | ○ |

2. Please mark the most important items affecting your health (maximum of 5 items) ↑

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A. Notifier: **MICHAEL SETZEN, MD**

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. Procedure/Code: | | | | | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|---|---|---|---|
| **Audiology:** | 92550 | _____ | 92568 | _____ | Medicare may cover only two (2) hearing tests per 365 days and fiberoptic examinations of the nose, sinuses and larynx may only be covered once in 180 days despite medical necessity, as determined by your physicians. Medicare may deny payment for that service. Medicare will be provided appropriate information and documentation to assist in their determination. | AS PER MEDICARE ALLOWED FEES |
| | 92557 | _____ | 92569 | _____ | | |
| | 92562 | _____ | 92570 | _____ | | |
| | 92563 | _____ | 92587 | _____ | | |
| | 92567 | _____ | 92588 | _____ | | |
| **Laryngoscopy:** | 31575 | _____ | | | | |
| **Sinus/Nasal Endoscopy:** | 31231 | _____ | | | | |
| **Transnasal Esophagoscopy:** | 43200 | _____ | 43202 | _____ | | |
| **FEESST:** | 92610 | _____ | 92616 | _____ | 92617 _____ | |

**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: |
|---|---|
| | |