New Patient Registration Package
Michael Rothschild, MD

Hello, and welcome to my office! I know your time is valuable, so I have prepared this package to speed up registration. By filling these out before your first visit, we can keep the time spent in the waiting room as short as possible. The forms can be printed out and faxed (212-996-2703), mailed or brought into the office. However, the BEST way of doing this is to simply fill out the forms digitally and emailing them to us, especially for telemedicine consults.

You can use the free Adobe Acrobat software to fill out and sign these forms, available for desktop/laptop computers or mobile devices. You can also use Preview on a Macintosh computer. Just save a copy of this document on your computer or device, fill out the boxes, use the "sign" tool for the spaces that need a signature, and then share it by emailing it to staff@parkavenueent.com. I know that there may be technical issues with this, so feel free to reach out if there is any problem.

There are four main documents in the registration package:

1) **New Patient Registration Form**: Please fill this out as completely as possible, including the name of your child's primary care doctor. You can email us a photo of both sides of your insurance card (or we can make a photocopy in the office), so you only need to complete the insurance section if you do not have the actual card.

2) **Medical History Form**: Please fill this out as completely as possible, provide the reason for this consultation, any other medical issues, past surgery, allergies to medications, other allergies, height, weight, and any current medications.

3) **Acknowledgement of Financial and Privacy Policies**: This document outlines the policies of our practice with regard to health insurance, payment for services and patient privacy (including the relevant federal HIPAA regulations). Please complete and sign this form, acknowledging that you have received our notice of privacy practices, and that you understand our office financial policies. If you prefer not to include a credit card number on this form, you can call the office with that number.

4) **Online Patient-Doctor Communication handout**: This document explains the risks and benefits of electronic doctor-patient (and doctor-family) communication, including telemedicine. I need your consent if we are to communicate remotely in any way about you or your child.

Feel free to contact me if you have any questions about these forms.

Best Wishes,

Michael Rothschild, MD

MICHAEL A. ROTHSCHILD, M.D.
NEW PATIENT REGISTRATION
T: 212-996-2995 F: 212-996-2703
www.KidsENT.com

Today's Date_____/_____/_____

PATIENT INFORMATION

Name of Patient (Last, First Middle)_____

Gender: ☐ Male ☐ Female Date of Birth _____

Siblings In Our Practice:_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Patient Lives With?_____ Relation to Patient_____

Parent Name_____ Parent Name_____

Home Phone_____ Home Phone_____

Work Phone_____ Work Phone_____

Mobile Phone_____ Mobile Phone_____

Email (Optional)_____ Email (Optional)_____

Relation to Patient_____ Relation to Patient_____

Emergency Contact (not in same household)_____ Phone_____

BILLING: Please complete for policyholder or person responsible for bills.

Name_____ Relation to Patient_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION: Please fill this out if we have not been able to make a copy of your current health insurance card.

Primary Ins _____ ID#_____

Ins Co. Address_____ Phone_____

Subscriber/Policy Holder_____ Relation to Patient_____

Secondary Ins _____ ID#_____

Ins Co. Address_____ Phone_____

Subscriber/Policy Holder_____ Relation to Patient_____

MEDICAL CONTACT INFORMATION: A written report will be sent to the primary care physician (PCP) unless otherwise instructed.

Pediatrician or PCP_____ Pharmacy_____

Phone_____ Phone_____

Address_____ Address_____

_____ _____

Other Referral Source_____

MICHAEL A. ROTHSCHILD, M.D.
NEW PATIENT HEALTH HISTORY FORM
T: 212-996-2995 F: 212-996-2703
www.KidsENT.com

Today's date:_____

Patient Name: _____ Date of birth:_____

Age:_____ Gender: ☐ Male ☐ Female Height:_____ Weight:_____

Reason for Consultation (check all that apply):

☐ Ear Infections	☐ Lump in Neck	☐ Foreign Object in Ear	☐ Headache	☐ Snoring / Apnea
☐ Ear Pain	☐ Sinus Problems	☐ Foreign Object in Nose	☐ Vertigo/Dizziness	☐ Other Sleep Problem
☐ Ear Drainage	☐ Facial Pain	☐ Facial Injury/ Fracture	☐ Tongue Tie	☐ Speech Delay
☐ Ringing in Ears	☐ Nasal Obstruction	☐ Sore Throat	☐ Noisy Breathing	☐ Pronunciation problem
☐ Hearing Loss	☐ Runny Nose	☐ Difficulty Swallowing	☐ Hoarseness	☐ Second Opinion
☐ Earwax Build-Up	☐ Nose Bleeds	☐ Infant Feeding Problem	☐ Other _____	

Chief Complaint:_____

Duration of current problem:_____ Date problem first noticed:_____

Intensity of symptoms: ☐ Not Applicable ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

What relieves symptoms?_____

What makes symptoms worse? _____

Is there a time of day or year that makes the symptoms worse?_____

Review of Systems – please check yes or no, and explain any current or past conditions or operations below

Yes	No		Yes	No		Yes	No	
☐	☐	ENT Problem other then above	☐	☐	Skin Disease/Rash	☐	☐	Heart Condition
☐	☐	Unexplained Weight Loss	☐	☐	Endocrine Condition	☐	☐	Muscle/Bone Condition
☐	☐	Unexplained Tiredness	☐	☐	Blood Disorder	☐	☐	Neurological Condition
☐	☐	Stomach/Bowel Conditions	☐	☐	Eye/Vision Problems	☐	☐	Immune Disorder
☐	☐	Breathing Problems	☐	☐	Emotional/Behavioral Problems	☐	☐	Urinary/Kidney Disorder
☐	☐	Other Problem(s):_____						

PAST MEDICAL HISTORY: Please describe current or past medical conditions, as well as any operations with dates
MEDICATIONS: List ALL medications currently being taken, including herbs, supplements and over the counter meds
ALLERGIES: Please list all food, medication and other allergies, including all reactions.

FAMILY HISTORY: Please list any known conditions that may run in the patient's family.

Condition	Relative

Physician Notes:_____

_____

Parent/Guardian signature Date Physician Signature Date

Rev 3/31/20

Michael Rothschild, MD

Acknowledgement of Privacy and Financial Policies

Patient Name: _____ Date of Birth:_____

Welcome to my office! Please read these policies and let us know if you have any questions.

Notice of Privacy Practices: In compliance with federal law, we are pleased to provide you with access to our Notice of Privacy Practices (NPP). This is available on our website at www.KidsENT.com/privacy. If you prefer to have a printed copy of this notice, it is available at the front desk. If you have questions for the practice privacy officer, email privacy@KidsENT.com or call (212) 996-2995.

Financial Policies: I know that managing payment for medical services can be confusing and frustrating. I want you to understand that I and my office staff will always do our best to help you navigate these systems, and keep your out-of-pocket expenditures to a minimum. Nevertheless, we are constrained by a number of regulations from the government and from private third party insurance companies, with which we must comply. If you have questions about any such matter, please feel free to contact my biller at (212) 996-2995 or by email at billing@kidsent.com.

I participate in a number of insurance plans. For a current list, check with my front desk staff. If you (or your child) has insurance for which I am an in-network provider, you will be responsible for all copayments at the time of service. You also may have in-network deductible and coinsurance responsibility for services and procedures. Once we receive the explanation of benefits (EOB) from your insurance company, we will send you a billing statement for any balance owed.

If I am not an in-network provider for your insurance plan, you still may receive out-of-network benefits, but payment in full is due at the time of service. As a courtesy, we are happy to submit the claim form and necessary supporting documents for your reimbursement. We will work to help you get the full benefits of your plan, but you will need to contact your insurance company directly for details regarding your out-of-network coverage.

Some insurance companies require a referral from your child's primary care provider. It is your responsibility to obtain this referral prior to your appointment. Remember that referrals eventually expire. If your insurance plan requires a referral, and if we do not have a current referral on file and you still wish for your child to be seen, we will have to collect full payment at the time of the visit.

If a minor child is brought to see me, the parent who consents to this consultation will be considered the responsible party for billing, as above. In cases of divorced or separated parents, any special and/or court-ordered arrangements involving consent for care and billing must be settled ahead of time by the parents (and their attorneys, if necessary). My office staff cannot be involved in such disputes. Of course, any parent who is a legal guardian of one of my patients is entitled to information about their clinical management, no matter who is financially responsible for care or if they were present at the time of consultation.

We understand that unexpected events occur, and we ask that you contact the office as soon as possible to cancel or reschedule your appointment if necessary. In the event that you do not arrive for your scheduled appointment and do not notify us ahead of time, you may be charged a cancellation fee. If you are more than 10 minutes late for your appointment, your child will still be seen but as a "fit-in", but if the office is busy you may be delayed.

During your child's office visit, it may be necessary to use one or more diagnostic procedures, such as nasal endoscopy, flexible laryngoscopy, microscopic cerumen removal or audiology (hearing testing). Your insurance company may list these procedures for billing purposes as "surgical" in nature, even though they are not operations and they are performed in the office. Just like the fee for the office visit, these will be billed as either in-network or out-of-network (depending on your coverage) and you will be responsible for copayments, deductibles, coinsurance charges and any costs not covered by your insurance company.

I do not accept Medicare or Medicaid in this office. You will be responsible for payment at the time of service, and if applicable will be required to sign a Medicare release form.

We accept cash, checks, Visa, Mastercard, American Express, Discover or Debit cards.

Agreement to Financial and Privacy Policies

As the person financially responsible for services rendered by Dr. Rothschild to the abovenamed patient, I authorize that my insurance benefits be paid directly to Dr. Rothschild. I also agree to forward to Dr. Rothschild any funds that I receive from my insurance company if they are not reimbursement for payments that I have already made. This may include payment for audiological services, tests and procedures.

I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, copayments, and coinsurance charges. I authorize any holder of medical information about the abovenamed patient to release to the Health Care Financing Administration and its agent or any other health insurance, any information needed to determine these benefits or the payable for related services. I authorize Dr. Rothschild's office to charge my credit card on file for any outstanding balances.

I have read and understand the above policies, and have been given opportunity to ask for clarification. I also acknowledge that I have been provided online or print access to this office's Notice of Privacy Practices, and have therefore been advised of how health information about the abovenamed patient may be used and disclosed by this office, and how I may obtain access to and control this information.

_____

Signature of patient, or of legal guardian if patient is under 18 years of age Date

_____

Printed name of legal guardian and relationship to patient, if patient is under 18 years of age Date

_____

Credit card number (if photocopy of card not obtained)

_____ _____

Credit card expiration date Credit card security code

About Telemedicine & Online Patient-Doctor Communication

Michael Rothschild, MD
Clinical Professor
Director, Pediatric ENT, Mt. Sinai Medical Center

1175 Park Avenue, 1A, NY, NY 10128
(212) 996-2995
www.KidsENT.com

Hello, and thanks for inquiring about online communication with me and my office staff! I know that the informed consent form is a little scary and may make you more concerned about the risks of using the Internet or other electronic systems for health care communication. Therefore, I would like to put this into context using basic, non-legal terms.

I think that online communication is a terrific supplement to the traditional method of contacting your doctor (the telephone), and I encourage its appropriate use. Many of the risks outlined in the consent document could well be applied to telephone, but since phone contact is such a deeply ingrained part of our culture, we don't really think about "telephone risks" the same way.

I have been using various forms of electronic communication to stay in touch with my patients' families for many years, and have had nothing but positive feedback. The ability to touch base without playing "telephone tag" and to get a full, thoughtful answer that can be reviewed later as needed is certainly a significant benefit for both patients and/or their parents and the doctor.

Security, privacy and computer virus risks have been addressed over the years with varying degrees of success. No computer system anywhere can ever be completely secure. However, I feel that if reasonable precautions are taken by both parties, electronic communication between doctors and patients can be at least as private and secure as a telephone call or the traditional paper chart.

One important thing to keep in mind when using electronic communication is that there are certain limitations. Even though I am in the habit of checking my e-mail and other messages frequently, there is no guarantee that you will always get a rapid response. Technical failures, out of town travel, and other factors may delay or prevent my response, so please call the office with any emergencies. The phones are answered 24 hours a day, seven days a week, and there is always someone available to take the call.

Please give me as much information as you can in the message. I see many patients with similar problems. Without the chart, I may not have all of the details of your child's case at my fingertips. I would like to be able to answer many questions right away, and not wait until I am in the office and can get the chart. If you give me some basic information in the message, it may help me to give you quicker and more accurate answers.

With telemedicine consults, realize that there are fundamental limits to what I can diagnose and manage without an in-person visit. Nevertheless, there are circumstances where this is a reasonable alternative, when minimizing office visits is desirable.

Finally, remember that no matter how secure I make my end of the communication, you need to observe basic privacy and security practices at your end as well (for example, don't share passwords, don't leave email systems open on a public computer, etc..). With a little bit of effort, we can make electronic communication a valuable and safe feature of my medical practice.

Michael Rothschild, MD

MR@KidsENT.com

Consent for Telemedicine & Online Patient-Doctor Communication

Michael Rothschild, MD
Clinical Professor
Director, Pediatric ENT, Mt. Sinai Medical Center

1175 Park Avenue, 1A, NY, NY 10128
(212) 996-2995
www.KidsENT.com

1. RISKS OF REMOTE CONTACT:

   Dr. Michael Rothschild (hereafter known as the provider) offers the patient and or patient's guardian (hereafter knowns as patient/guardian) the opportunity to communicate with the provider electronically, including telemedicine consultations. This type of remote contact has a number of risks that the patient/guardian should consider before using this mode of communication. The use of advanced online security features reduces, but may not eliminate, all of these risks. These include, but are not limited to, the following:

   a. Remote contact through electronic means can never completely replace an in-person physical examination. Inaccurate or missed diagnoses and management errors can be due to technical issues or the fundamental limits of remote evaluation. If there is any concern, in-person evaluation is recommended, either by the provider when possible, or through an emergency medicine facility.
   b. Video conferencing and messaging system can never be 100% secure, and the possibility always exists of content interception, alteration, forwarding or use without authorization or detection.
   c. Messages can be circulated, forwarded, and stored in physical or electronic form.
   d. Messages can be broadcast worldwide and received by unintended recipients.
   e. Messages can be misaddressed
   f. Electronic documents are easier to falsify than handwritten and/or signed documents
   g. Backup copies of messages may exist even after the sender or the recipient has deleted their copy.
   h. Employers and online services have a right to archive and inspect material transmitted through their systems.
   i. Online communication can be used to introduce viruses into computer systems.
   j. Messages can be used as evidence in legal proceedings.

2. BENEFITS OF REMOTE CONTACT:
   a. Remote contact may be preferable when conditions make in-person consultation inherently risky (e.g. during any sort of epidemic of an infectious disease)
   b. Remote contact is often more convenient for the patient/guardian, and may be asynchronous to allow for time constraint
   c. Remote contact is self documenting, which is a benefit to the patient/guardian when later review is required.

3. CONDITIONS FOR USE OF ONLINE CONTACT:

The provider will use reasonable means to protect the security and confidentiality of information sent and received electronically. However, because of the risks outlined above, the provider cannot guarantee the security and confidentiality of online communication, and will not be liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct. Thus, the patient/guardian must consent to the use of the Internet or other electronic means for the transmission of medical information. Consent to the use of electronic communication includes agreement with the following conditions:

   a. All messages to or from the patient/guardian may be printed out and made a part of the patient's medical record. Because they are a part of the record, other individuals authorized to access the record (such as staff and billing personnel) will have access to these messages.
   b. The provider may forward these messages internally within the practice to the staff and agents as necessary for diagnosis, treatment, reimbursement and other handling. The provider will not, however, forward messages to independent third parties without the patient's/guardian's prior written consent, except as authorized and required by law.
   c. Although the provider will endeavor to read and respond promptly to messages

Initially adapted from Health Information Compliance Insider, Brownstone Publishers, 2001. Last revised 3/26/20

from the patient/guardian, the provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient/guardian shall not use the Internet or texting for medical emergencies or other time-sensitive matters in place of more immediate methods of contact (i.e. telephone)

d. If the patient's/guardian's message requires or invites a response from the provider, and the patient/guardian has not received a response within a reasonable time period, it is the patient's/guardian's responsibility to follow up to determine whether the intended recipient received the message and whether the recipient will respond.
e. The patient/guardian should use careful judgment before using electronic systems to communicate regarding sensitive medical information, such as that involving sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
f. The patient/guardian is responsible for informing the provider of any types of information the patient/guardian does not want to be transmitted electronically, in addition to those mentioned in 2e above.
g. The patient/guardian is responsible for protecting his or her password or other means of access to their electronic communication system. The provider is not responsible for breaches of confidentiality caused by the patient or any third party.
h. The provider shall not engage in online communication that is otherwise deemed unlawful.
i. It is the patient's/guardian's responsibility to follow up and/or schedule an appointment as necessary.

4. INSTRUCTIONS:
   To communicate electronically, the patient/guardian shall:

   a. Inform the provider of any changes in his or her Internet or telecommunications access that would affect communication
   b. Include the patient's (and guardian's) full name in any messages
   c. Follow any and all instructions generated by the messaging system, including requested information to facilitate message delivery
   d. Review the message to ensure that all relevant information is included before sending it to the provider
   e. Take precautions to preserve the confidentiality of online messages, such as preventing the use of his or her computer by unauthorized persons.
   f. Withdraw this consent by written communication with the provider.

5. PATIENT/GUARDIAN ACKNOWLEDGMENT AND AGREEMENT:

I acknowledge that I have read and fully understand this consent form. I understand the risks and benefits associated with electronic communication with this health care provider, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the provider may impose to communicate with patients/guardians electronically. Any questions that I may have had were answered.

_____
Email address for desired contact

_____
Patient Name

_____
Patient Date of Birth

_____
Guardian name (if patient is under 18)

_____
Relationship of guardian to patient

_____
Patient signature (or guardian if under 18)

_____
Date signed