Fingerlakes ENT & Skin Oncology
DOUGLAS W. HALLIDAY, Ph.D., M.D
7 Fennell Street
Skaneateles, NY 13152
TEL: (315) 685.0247 FAX: (315) 685.0222

APPOINTMENT POLICIES AND PROCEDURES

You will receive a reminder call approximately 2 days in advance of your appointment
If you wish not to receive reminder calls or reminder emails, please advise us at least 5 days prior to your appointment.

Please bring the following information with you to your appointment:

Please print out, complete, and bring with you to your appointment.
Please h*and deliver to our front desk team on arrival.*

- Please fill-in all information.
- Please sign and date all forms that request signatures and dates.
- Bring your insurance card(s) with you to your appointment. *If you do not have your insurance card with you, payment will be expected at the time of your visit.*
- Bring your Driver License. We need to identify you and it matches the insurance information.
- ***Please hand carry any CT Scans & MRI films with reports.***
- *Please bring any related medical records that will assist us in your treatment.*

- No-Fault You Must have the following at the time of your appointment or we will have to reschedule.
  - The date of injury/accident.
  - Name of insurance carrier w/address & phone number.
  - Case number and/or Reference number.
  - Any other relevant information regarding your case.

Co-Pays and Self Pay Fee's

Any copays and self-pay fees are due at time of visit.
We accept cash, check, debit cards, American Express, Visa, MasterCard, Discover and Care Credit.

Referrals

Referrals are not necessarily required; this depends on your insurance. If a referral is required, please be sure you obtain one prior to your visit or we will have to reschedule you.

Cancellations / Rescheduled Appointments:

Please understand that we have No-Show fee of $25 that will be billed in the event you do not call or email us within 24 hours. We understand that emergencies and unpredictable circumstances arise and are a part of life, and if you must make a short notice change, please call our main office directly and respect the time we have dedicated to you.

I have carefully read the above office policy, as well as understanding and agreeing to the terms and conditions.

Signature: _____ **Date**:_____
Rev 11/2020

Directions to 7 Fennell Street
Skaneateles, NY 13152

Free Parking/Handicap Accessible

From Auburn

Head north on South St toward Genesee St and turn right at the 1st cross street onto Genesee St
5.5 mi.
Continue onto Hwy 20 E/U.S. Rte 20
Turn left at the light in the center of town onto Jordan St, then take your first left hand turn onto Fennell Street. A little way up you will see on your left a grey and white building, our signage out front with free parking in the front and the back.

From Fayetteville/Manlius Area

Head west on NY-173 W/E Seneca St toward Mill St. and continue to follow NY-173 W8.3 mi
Turn left onto NY-173 W/E Seneca Turnpike, 2.6 miles
Use the left 2 lanes to turn slightly left onto NY-175 W 8.0 mi
Turn left onto NY-174 S/NY-175 W and continue to follow NY-175 W
5.0 mi, turn right onto Hwy 20 W/E Genesee St/U.S. Rte. 20, 1.9 miles
Turn right onto Jordan St and take first left onto Fennell St, our grey and white building has signage out front with parking in the front and the back.

From Camillus

Head west on W Genesee St toward Leroy Street about 0.7 miles. Continue onto NY-174 N/W Genesee Turnpike and continue to follow W Genesee Turnpike 2.6 mi.
Turn left onto NY-321 S and go 6.6 mi
Take a Slight right onto Old Seneca Turnpike for approximately 0.8 mi
Turn left onto Jordan Rd, drive 1.2 mi, Turn right onto Fennell St
our grey and white building has signage out front with parking in the front and the back.

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Fingerlakes ENT & Skin Oncology
Douglas W Halliday, MD, PH.D

Please Print

NAME _____
FIRST MIDDLE INITIAL LAST

DATE OF BIRTH _____AGE_____ SEX (CIRCLE) M F MARITAL STATUS (CIRCLE): S M D W

ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

EMAIL ADDRESS _____

HOME PHONE#_____ CELL# _____WORK#_____EXT_____
[indicate area code if other than (315)]
EMERGENCY CONTACT: NAME/RELATIONSHIP _____ PHONE#_____

PHARMACY NAME/ADDRESS/PHONE _____

NAME OF YOUR PRIMARY CARE PHYSICIAN _____PHONE# _____

NAME OF REFERRING PHYSICIAN _____PHONE# _____

EMPLOYED BY: _____PHONE# _____

NAME OF SPOUSE: _____ SPOUSE DOB: _____

SPOUSES EMPLOYER _____

HOW DID YOU HEAR ABOUT US? (CHECK/NAME ALL THAT APPLY)
Friend/Colleague-Please indicate name if appropriate_____
Internet Search _____Website _____ Magazine_____ Real-Self_____ Business/Salon/Spa_____

IF PATIENT IS UNDER 21, PLEASE INDICATE THE FOLLOWING: STUDENT (circle): **FT PT N/A**

NAME OF FATHER_____ DOB_____

SS#_____-_____-_____ EMPLOYER_____ WORK#_____

NAME OF MOTHER_____ _____ DOB_____

SS#_____-_____-_____ EMPLOYER_____ WORK#_____

IF DIFFERENT ADDRESS THAN ABOVE, PLEASE INDICATE _____

INSURANCE

PLEASE FILL-IN ALL INSURANCE INFORMATION
IF YOUR CLAIMS ARE NO FAULT/WORKERS COMPENSATION (PLEASE LET US KNOW AND ASK FOR ADDITIONAL PAPERWORK)

NAME OF PRIMARY INSURANCE
SUBSCRIBER_____ID#_____GROUP#_____

SECONDARY INSURANCE
SUBSCRIBER_____ID#_____GROUP#_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO D W Halliday MD PHD PLLC

SIGNATURE _____ **DATE** _____
Rev 11/2020

Patient Authorization & Consent Form for
HIPAA LAW 164.506 AND 164.508
(Health Insurance Portability and Accountability Act)

In order to maintain your Patient Rights under the HIPAA LAW 164.506 and 164.508, we need to inform you of the following ways that your personal information can be used in order to render your care. If for any reason you do not want us to use your information in any of the manners listed below, please place a single line through that entry and write "refused" at the end of the particular entry.

I _____ understand and give consent to D W Halliday MD PHD PLLC , to receive payment from my insurance carrier and to obtain all necessary information to render care to me including: Transmission of my treatment and care rendered by this practice to my insurance carrier via electronic or paper claims submission for billing purposes.

Notification of my health care needs to my primary care or other involved physicians, through written documentation that may be faxed, e-mailed or sent through the US Postal service.

I also understand that D W Halliday MD PHD PLLC may also be receiving information from my various physicians in the same manner through, facsimiles, e-mail and the US Postal Service.

I also understand that if testing is required and specimens are collected and sent out to various laboratories and pathology sites, pertinent information about myself such as name address, date of birth, social security number, pertinent diagnosis and insurance information may be sent along with such specimens for the purpose of processing.

I also understand that if surgery of any type is required and a medical clearance is needed, my primary care physician's office may be contacted and the appropriate appointments and arrangements may be made by the staff of D W Halliday MD PHD PLLC . These appointments may include blood work, physicals and other testing procedures. The outcome of these appointments may be received by facsimile and/or e-mail and then shared with the designated surgery center and the anesthesiologist who will be involved in my care.

I also understand that billing information will be shared with any entity involved in my care, for the purpose of payment of services only.
I also understand that in order for the office of D W Halliday MD PHD PLLC to maintain patient flow, I will be required to verbally check-in for my appointment with a receptionist.
I also understand that my name will be called aloud when the technical staff is ready for me in the exam area, or when any other staff member is in need of my personal attention at their station.

I also understand that in the event of an emergency D W Halliday MD PHD PLLC tries to obtain my consent as soon as reasonably practical after the delivery of treatment. If he is unable to obtain my consent, he may still use or disclose my health information.

I also understand if D W Halliday MD PHD PLLC tries to obtain consent but is unable to do so due to substantial communication barriers and D W Halliday MD PHD PLLC determines, using professional judgement that you intend to consent to use or disclose under the circumstances.

We may disclose your private health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls, to make repairs or replacements.
By acknowledgment of this information, I authorize DW Halliday MD PHD PLLC o bill my insurance carrier(s) and I understand that any information pertinent to the findings of my exam can be released to my insurance carrier(s). I have the right to refuse billing to my carrier and understand that I am financially responsible for all visits here whether deemed self pay or non-covered service determined by my insurance carrier to be the responsibility of the insured. This includes, co-payments, co-insurance payments, deductibles, and not medically necessary treatments.

SIGNATURE_____ **DATE**_____
REV 10/2019

D W Halliday MD PHD PLLC Financial Policy

Thank you for choosing our practice to provide your care. We value you as a patient and wish to make you aware of our financial policies. We require that you read and sign this document prior to seeing the provider.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please kindly call our office within 24 hours to reschedule. This will allow us to provide this time slot to another patient.

No Insurance: Payment will be due at time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our front desk or billing manager.

Insurance: Please bring your insurance card with you at each appointment. It is your responsibility to provide our office with your current insurance as well as updating us of any changes in insurance. With insurance plans where we have agreed to participate as a network provider, carriers require that all copay's be paid prior to services being rendered. The copay cannot be waived, as it is a requirement placed on you by your insurance carrier. For your convenience, we accept cash, check, credit card, and Care Credit.
You are responsible for any copays, co-insurance, deductible or non-covered services not paid by your insurance. You will receive a statement from our office indicating what your insurance has paid and what the amount of your responsibility is. The payment will be due upon receipt.

Non-Covered Services: Some services we provide may not be deemed medically necessary by your insurance carrier or may be a non-covered service benefit by your specific policy and therefore not paid by your insurance carrier. Most cosmetic procedures are not covered i.e. Skin Tag Removal. We cannot bill your insurance for any cosmetic procedures.

Laboratory services: Some services such as biopsies and other specimens will be sent to an outside lab for evaluation. In those circumstances, the patient will receive a separate bill from the lab where the specimen was sent to.

Returned Check Policy: A $25.00 fee will be charged for each check that is returned for insufficient funds

ABN: In certain situations, we may ask you to sign an ABN. An Advance Beneficiary Notice (ABN), also known as a waiver of liability, is a notice a provider should give you before you receive a service if your provider has reason to believe your insurance may not pay for the service or does not provide preauthorization.

ASSIGNMENT AND RELEASE
I, the undersigned, assign directly to D W Halliday MD PHD PLLC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.
I further authorize D W Halliday MD PHD PLLC to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

FINANCIAL AGREEMENT
I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature_____ **Date**_____
Rev 10/2019

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HIPAA AUTHORIZATION

Please answer all of the questions below. It is important and helpful to our practice to relay information to others from your direction to your family. Please list below anyone including family and friends, that you would authorize us to give them your health information.

Contact #1 Name:_____Phone No._____

Contact #2 Name:_____Phone No._____

Contact #3 Name:_____Phone No._____

Please circle your response to each question below.

Is it okay for our office to leave a message on your cell phone? Yes or No

Is it okay for our office to leave a message on your home answering machine? Yes or No

Is it okay to email you? Yes or No

Is it okay to send you a text message? Yes or No

FINGERLAKES ENT & SKIN ONCOLOGY / FINGERLAKES MEDICAL AESTHETICS

NAME ______________________________DOB__________HEIGHT_______WEIGHT_________AGE_______

How were you referred Here?_________________________________

PAST MEDICAL HISTORY

□ Heart Attack / Date___________
□ Pacemaker or □ AICD (Internal Defib)
□ Stroke or TIA's
□ Aneurysm
□ History of Angina or Chest Pain
□ High Blood Pressure
□ High Cholesterol
□ Mitral Valve Prolapse
□ Shortness of Breath
□ Asthma
□ COPD/Emphysema
□ Heavy Snoring or Sleep Apnea
Use of CPAP or BIPAP Yes or No
□ Broken Nose (When)_____________
□ Chronic Mouth Breathing

□ Kidney Disease
□ Liver Disease
□ Diabetes
Need Daily Insulin Yes or No
□ Thyroid Disease
□ Autoimmune Disease____________
□ Bleeding Disorder__________
□ Blood Clots/DVT's or PE
□ HIV/AIDS
□ Cancer (Type)__________________
□ Hepatitis (Type)_________________
□ MRSA
□ Limited Neck Mobility
□ Fibromyalgia/Restless Leg Syndrome
□ Skin Conditions(Type)____________
□ Psychiatric Disorders
Depression ______Bipolar ____
□ Other Problems/Disorders
____

SOCIAL HISTORY

OCCUPATION: ________________
Live Alone Yes or No
Do you feel safe at home? Yes or No
Did you get the flu shot this year Yes or No
PET(S) Type__________________

TOBACCO USE
□ Smoker: Yes Or No
If yes, ____ packs for _____ Yrs
□ Stopped Smoking WHEN? ______
ALCOHOL USE (circle one)
How Many Drinks a week?
___Do Not Drink Alcohol
1-3 Days 3-5 Days Everyday
DRUG USE
□ Recreational Drug Use Yes or No
Type(s):________________________
Do you Exercise? Yes or No
How often do you exercise?________

PAST SURGICAL HISTORY

Procedure	Date
______________________	_______________
______________________	_______________
______________________	_______________
______________________	_______________

FAMILY HISTORY

M-Mother F-Father S-Sibling
M F S Diabetes
M F S Heart Disease
M F S Bleeding Disorder
M F S Cancer(Type)_________

MEDICATIONS

Please include vitamins, herbals, ASPIRIN, nasal spray, prescriptions, and any over the counter items

Name	Dosage
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

ALLERGIES

Please Circle or list any allergy below
Drug Medication(S)_____________________
Iodine or Shellfish
Epinephrine
Lidocaine
Penicillin
Sulfa

Do you have any metal in your body?
Yes or No?

Updated HH Form

Date	Temp	BP	Initials
_____	_____	_____	_____