Fingerlakes ENT & Skin Oncology
Fingerlakes Medical Aesthetics
Douglas W. Halliday, Ph.D., M.D
Cherice Stebbins, APRN, FNP-BC

7 Fennell Street
Skaneateles, NY 1312
TEL: (315) 685.0247
FAX: (315) 685.0222

Cicero Professional Building, 6221 Route 31, Ste 105
Cicero, NY 13039
TEL: (315) 752.3000
FAX: (315) 752.3017

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 let us know.

Please bring the following Information with you to your appointment:

Please print out, complete, and bring your new patient paperwork to your first appointment.

- 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.
- Please bring your covid vaccination card and booster if applicable

- No-Fault Please bring the following information, or we will have to reschedule you.
  - 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 usually required* any longer, however a couple of insurance companies still require such as UnitedHealth Care Community Plan and Fidelis. If a referral is required, please be sure one is in place before you are seen. You may be asked to reschedule or be responsible for the visit.

Cancellations / Rescheduled Appointments:

Please understand that we do not implement a No-Show fee, however we do ask as a courtesy to please call our office or email us at amber@fingerlakesmd.com within 24 hours of your scheduled appointment. We understand that emergencies and unpredictable circumstances, such as the weather here in Central New York arise, and are a part of life. If you do need to make a short notice change, please call our main office directly and respect the time we have dedicated for you!

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

Signature: _______________________________________Date:.____________________

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Fingerlakes ENT & Skin Oncology/Fingerlakes Medical Aesthetics

Name:________________________DOB _________________Height _____ Weight ____ Age____
Occupation:___________________ How were you referred Here?____________________

Do you live alone? Yes or No
Do you feel safe at home? Yes or No
Last Year of Flu Shot ________
Are you COVID Vaccinated? Yes or No
COVID Booster Yes or No
Do you have any metal in your body? If yes, please list where.____

PAST MEDICAL HISTORY

_Heart Attack/Date___
_Pacemaker or A/CD
_Stroke or TIA's
_Aneurysm
_Angina or Chest Pain
_High Blood Pressure
_High Cholesterol
_Mitral Valve Prolapse
_Shortness of Breath
_Asthma
_COPD/Emphysema
_Snoring/Sleep Apnea
_Use of CPAP or BIPAP
_Broken Nose___Date
_Mouth Breathing
_Kidney Disease
_Liver Disease
_Diabetes_Daily Insulin
_Thyroid Disease
_Autoimmune Disease
_Bleeding Disorder
_Blood Clots/DVT or PE
_HIV/AIDS
_Cancer/Type____
_ Hepatitis/Type___
_MRSA
_Limited Neck Mobility
_Fibromyalgia/Restless Leg
_ Psychiatric Disorders
_Depression___Bipolar
_Other Problems/Disorders
____

PAST SURGICAL HISTORY

(Please List only ENT Head and Neck Related)

Procedure Date

Please list only ENT Head and Neck Related

Procedure	Date
______________________	______________
______________________	______________
______________________	______________
______________________	______________
______________________	______________

UPDATED HH FORM

Date	Temp	Initials

MEDICATIONS

Please include vitamins, herbals, aspirin, nasal sprays, prescriptions, and anything over the counter.

____
____
____
____
____
____
____
____
____

ALLERGIES

Please Circle or List any allergies you have
Drug Allergy(ies).________________

Lodine or Shellfish
Epinephrine Lidocaine
Sulfa
Penicillin

SOCIAL HISTORY

If you have any pets, please list:
____

Alcohol Use
__ I do not drink any alcohol
___ I drink____drinks per week

Tobacco Use
Have you ever smoked? Yes or No
If Yes, how much daily, for how long?_____
If you have stopped, how long ago?______

Recreational Drugs
__ I do not use recreational drugs
__ I do use recreational drugs. I use_______________, daily/weekly

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Do you Exercise? Yes or No
If yes, how many times per week, and usually for how long?__ min/hours
When exercising, do you have difficulty breathing through your nose? Yes or No

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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#_____________

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

SIGNATURE ____ **DATE** ____________________
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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 below anyone including family and friends that you would authorize us to give them your health information to.

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 for our office to email you? Yes or No

Is it okay for our office to send a text message? Yes or No

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 bloodwork, 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 to 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:**______________________________

Finger Lakes ENT and Skin Oncology

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPM and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ 2. I **DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting Health Connections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

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, 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 08/2024