Florida Sinus & Snoring Specialists, LLC – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation: Mr.___ Mrs.___ Ms.____Miss____ Dr.____ Marital Status: M ___ S___ D ___ W___ Other___

Patient Name: _____ _Date of Birth: _____ Age: _____ Sex: F____ M ____

Reason for visit: _____

Please check appropriate response:

* *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Caucasian_____

Native Hawaiian/Pacific Islander_____ Other Race____ Declined to answer _____

Please check appropriate response:

**Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street City, State Zip

Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Patient's Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Pharmacy Name _____ Address_____ Tele# _____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ ____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

Whom we may thank for referring you, check box below?

_____ Radio _____ Internet _____Insurance _____Facebook _____Instagram _____Zocdoc _____ Mailer Campaign

_____Email Campaign _____TV _____Website _____Health fair _____ Magazine _____Airport

Friend/Relative (Name) _____ Family Dr. / PCP (Name) _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Florida Sinus & Snoring Specialists, LLC. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician/Physician Assistant and Florida Sinus & Snoring Specialists, LLC to photograph me for medically related documentation purposes. _____Yes _____No

Signature: _____ Date: _____

LEE M. MANDEL, M.D., F.A.C.S., F.A.R.S.
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STOP BANG Questionnaire

Screening for Obstructive Sleep Apnea

Answer only the **STOP** portion of this questionnaire.

STOP		
Do you Snore loudly? (Louder than talking or loud enough to be heard though closed doors?	**YES**	**NO**
Do you often feel Tired, fatigued, or sleepy during the daytime?	**YES**	**NO**
Has anyone Observed you stop breathing during your sleep?	**YES**	**NO**
Do you have or are you being treated for high blood Pressure?	**YES**	**NO**

Patient Signature Date

BANG		
BMI more than 35kg/m^2	**YES**	**NO**
Age over 50 years old?	**YES**	**NO**
Neck Circumference > 15.75in. (40cm)?	**YES**	**NO**
Male Gender	**YES**	**NO**

TOTAL SCORE	

OSA RISK

≥ 3 yes answers: high-risk for OSA

< 3 yes answers: low risk for OSA

Office Use Only: BMI: _____ Neck Circumference: _____cm

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

Interpretation:
0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Patient Signature Date

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Modified NOSE scale & VAS

Patient name: _____ Age_____ □Male □Female

Over the past 1 month, how much of a problem were the following conditions for you?

	Not a problem	very mild problem	moderate problem	fairly bad problem	severe problem
1. Nasal stuffiness or obstruction	0	1	2	3	4
2. Trouble breathing through my nose	0	1	2	3	4
3. Trouble sleeping	0	1	2	3	4
4. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

Please mark on this line how troublesome is your difficulty breathing through you nose:

|□□□□□□□□□□|□□□□□□□□□□|
None Medium Severe

_____ _____
Patient Signature Date

Patient Name: _____

I.D.:_____

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)_____ ↑

Patient signature & Date:_____

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England.

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Print Patient Name: _____
Date of Birth: _____

Financial Consent

I hereby authorize said assignee to release all information necessary to secure payment.

I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about to release to the above plan or its intermediaries or carries an information needed for this or any related insurance claim. I request that the payments of authorized benefits be made to Florida Sinus & Snoring Specialists, LLC. on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services and authorize such physician/organization to submit a claim to the above insurance on my behalf.

I understand that I am financially responsible for all charges not paid by my insurance, including any deductibles, co-pay, and co-insurance, and that payments are due at the time services are rendered.

I understand and agree that if I fail to make payment for services rendered to me, my name and account will be turned over to an attorney and/or a 3rd party collection agency and I agree to pay the additional administration for of 30% of the outstanding amount owed, including any court cost, and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

Privacy Consent

I have been provided a copy or access to a copy of the Practice's Notice of Privacy Practices.

Consent for Treatment

I hereby voluntarily consent to outpatient care at Florida Sinus & Snoring Specialists, LLC., encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), endoscopies, CT scans, audiology testing, allergy testing and treatment, and administration of medication prescribed by the physician or physician assistant. I understand that the above diagnostic procedures and testing are separate from my office visit and may be subject to deductible and co-insurance.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their mid-levels, including audiologists, medical assistants or their designees as is necessary in the physician's judgment.

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine. Please check response: □ Yes □ No

Patient Initials _____

PBM Consent

By signing this consent form, I am authorizing Florida Sinus & Snoring Specialists, LLC to request and use my prescription medication history from other health care providers and/or third-party pharmacy payors for treatment purposes.

Pharmacy Benefits Managers (PBM) are third party administrators, prescription programs, whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies which are lists of dispensable drugs covered by a particular benefit plan.

Appointment Reminders

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience without healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice. Based on the information being communicated, there may be a potential of multiple texts in order to provide necessary information. I acknowledge and consent to receive text messages from the practice to my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing or choose to opt out.

The practice does not charge for this service, but standard test messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Consent Forms Acknowledgment

I, the patient, hereby have read and understand the following:

- Financial Consent
- Privacy Consent
- Consent for Treatment
- PBM Consent
- Message Consent
- Appointment Reminders

Furthermore, I acknowledge I have been given the opportunity to ask questions regarding these consents.

Patient/Guardian Signature: _____ Date: _____

Medicare Consent (applies to Medicare Beneficiaries ONLY)

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carries, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits by made on my behalf. I assign the benefits payable for physician/audiology services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Patient/Guardian Signature: _____ Date: _____

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Consent for purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The above organization is not required to agree to the restrictions that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing, at any time, except to the extent that the above organization has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the above organizations Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bill or in the performance of health care operations of the above organization. The Notice of Privacy Practices is also provided at the above organization and on the website it applicable. This Notice of Privacy Practices also describes my rights and the above names organization's duties with respect to my protected health information.

The above named organization reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient or Personal Representative Signature of Patient or Personal Representative

Date Description of Personal Representative's Authority

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Patient Request for Email Communications

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Communications over the Internet and/or using email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email. In order to comply with your request, that this provider/program communicate with you via email you must complete this form and return it to your health care provider's office.

Please be advised that:

- This request applies to the healthcare provider that you indicate below. If you would like to request to communicate via email with another health care provider, you must complete a separate request for that office.
- Florida Sinus & Snoring Specialists, LLC, the office of Lee M. Mandel, M.D., will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS, substance abuse, mental health information) via email.
- You must provide your email address when registering for your visit with your provider.
- It is recommended that you send a test mail before corresponding via email.

I understand and agree to the following:

- I certify the email address on this request is accurate, and that I accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form, and have read, understand it and am authorizing my requested information be sent to me via the email address I provided above.
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure: that there is no assurance of confidentiality of information when communicated via email.
- I understand that all email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Florida Sinus & Snoring Specialists, LLC, the office of Lee M. Mandel, M.D. and individuals associated with it harmless from any and all claims and liabilities arising from or related to communication via email.

_____ _____

Signature of Patient Date

Name of Physician or Program: _____

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Payment policy

Please carefully read and sign this form as it concerns you, the patient.

****** You are Responsible for your Insurance Policy**

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy**. It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient or the financially responsible party, being responsible for all costs incurred. **Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out whether or not we are providers for your specific network.**

****** Referrals**

If you need a referral from your insurance company or from your Primary Care Physician to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you may be required to reschedule your appointment should a referral not be available. We welcome you to call your Primary Care Physician and have your referral faxed to us.

******Non-Participating Provider Policy**

If we are not a provider for your insurance company, we will collect our fees in full at the time of service.

****** Your Financial Responsibility**

You are responsible for your payment of any co-payments, deductibles and/or co-insurance at the time of service. Please note, copays, deductibles and or co-insurance will still apply to all future follow-up visits until your out of pocket has been met in full. Because we are specialists, some diagnostic/invasive procedures, may not be considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage to avoid confusion and out of pocket expense.

Signature of patient/Guardian Date

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RECORDS RELEASE

Date: _____

To: _____

_____

_____

I hereby authorize you to release to:

LEE MANDEL, M.D., F.A.C.S., F.A.R.S.

□ 950 South Pine Island Road
Suite A-180
Plantation, FL 33324
Tel: (954) 587-4218
Fax: (954) 587-4219

□ 1301 E. Broward Blvd
Suite 240
Ft Lauderdale, FL 33301
Tel:(954) 983-1211
Fax: (954) 983-4190

any information including the diagnosis and records of any treatment or examination rendered to me during the period

from: _____ to: _____

_____

_____ _____
Patient Name (Please Print) Date of Birth

_____
Patient Signature (Patient or person authorized to sign for patient)

_____
Witness Signature

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I, _____, authorize Florida Sinus & Snoring Specialists, LLC, the office of Dr. Lee Mandel to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons:

YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Authorization #1:
Name: _____
Phone #: _____
Relation to Patient: _____

Authorization #2:
Name: _____
Phone #: _____
Relation to Patient: _____

Authorization #3:
Name: _____
Phone #: _____
Relation to Patient: _____

Authorization #4:
Name: _____
Phone #: _____
Relation to Patient: _____

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please check response: □ Yes □ No

Print Patient Name: _____

Patient/Guardian Signature: _____

Patient D.O.B: _____