VIJAY K. ANAND, M.D., F.A.C.S
772 PARK AVENUE NEW YORK, NEW YORK 10021
TEL (212)452-3005 FAX (212)452-3660
EMAIL: vijayanandmd@gmail.com

Date of Birth:_____
Last Name:_____ First Name:_____
Home Address _____ Apt#_____
City_____ State_____ Zip_____
Home Phone#_____ Cell Phone#_____
Work Phone# _____ Social Security#_____
Sex_____ Marital Status ____M____S____D____W
Mother's First Name (Required) _____ Father's First Name(Required)_____
EMAIL_____

REFERRAL INFORMATION
How were you referred: ____Physician ____Family Member ____Friend ____Website
Name_____ Tel#_____
Address/City/State/Zip_____

EMPLOYER INFORMATION
Name of Employer_____ Work Phone_____
Address _____ Occupation_____

INSURANCE INFORMATION **If this is a workers comp or no fault case, please alert the receptionist**
Primary Insurance Co. Name_____
Policy or ID#_____ Group#_____
Policy Holder's Name _____ Relation ____Self ____Spouse___Parent
Policy Holder's SS# _____ Policy Holder's DOB_____

Secondary Insurance Co. Name:_____
Policy or ID#_____ Group#_____
Policy Holder's Name _____ Relation ____Self ____Spouse___Parent
Policy Holder's SS# _____ Policy Holder's DOB_____

EMERGENCY CONTACT
Name:_____ Relation_____
Home Phone # _____ Cell Phone#_____
Address/City/State/Zip_____

ASSIGNMENT OF BENEFITS (PLEASE SIGN BELOW)
I request the payment of authorized insurance carrier benefits be made on my behalf to Dr. Vijay Anand. M.D.,P.C., for any services rendered to me. I authorize the releaseof any medical information to my insurance carrier or the Health Care Financing Administration and its agents for the purpose of determining benefits payable for related services. Furthermore, I understand that the annual deductible amounts and all co-insurance amounts are my responsibility. If I have assigned my medical benefits to any other party (managed care plans we do not participate in), rendering this office ineligible for payment, I understand that I will be responsible for the entire bill for services. I also acknowledge that Dr. Vijay Anand, M.D.,P.C. is not financially responsible to reimburse me or any other party for any services not covered by outside providers which I may have been referred to. I have received the notice of Privay Practices (page 8) and I have had an opportunity to review it and ask questions.

Patient Signature:_____ Date:_____

Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue
New York , NY 10021

How did you learn about us: (Please circle your response):

My doctor Family Member A friend My own research/internet

New York Hospital/Cornell Dr. Anand's website

PLEASE CIRCLE THE CHIEF COMPLAINTS THAT HAVE BROUGHT YOU TO OUR OFFICE TODAY:

Nasal Congestion	Ear Pain
Nasal Discharge	Dizziness
Headache	Loss of Hearing
Cough	Ringing in Ears
Facial Pain/Pressure	Heartburn/Acid Reflux
Allergies	Difficulty Swallowing
Sinus Infection	Hoarseness
Difficulty Breathing	Throat Pain
Facial Trauma	Snoring
Loss of Taste	Sleep Apnea
Loss of Smell	Eustachian Tube Dysfunction
Pituitary Adenoma	Cerebrospinal Fluid Leak (CSF leak)

Other:_____

Vijay K. Anand. M. D., F.A.C.S.
772 Park Avenue
New York, N.Y., 10021

Thank you for allowing me to participate in your medical evaluation and treatment. Please fill out this questionnaire to help me assess your condition. This information allows me to tailor the most appropriate diagnostic and therapeutic treatment for you. Your responses will be made part of your electronic medical record and will be kept fully confidential.

MEDICAL HISTORY: Please check off (√) any health problems that you currently have or have had in the past:

_____ Heart attack _____Bleeding/clotting disorders _____ Diarrhea

_____Chest pain _____Unusual bleeding post surgery _____Constipation

_____Heart disease _____Lung problems or asthma _____ Liver disorders

_____High BP _____Tuberculosis _____ Stroke _____Hepatitis

_____High cholesterol _____Diabetes _____Epilepsy/convulsions

_____Thyroid disease _____Leg swelling/phlebitis _____Weight problems

_____Fatigue _____Stress _____Oral herpes _____

SURGICAL HISTORY: Have you ever had surgery?_____Yes _____No
If yes, please describe and provide dates:

FAMILY HISTORY: Do you have a family history of hearing loss? ____Yes _____No
Thyroid disease? _____Yes _____No. Please list any other pertinent family history:

GENETIC HISTORY: Hemophilia? ___Yes ____No. Thalessemia? _____Yes ____No
Tay-Sachs? _____Yes _____No. Congenital abnormalities? _____Yes _____No
If yes, describe congenital abnormalities:

INFECTION HISTORY: Please note and current or previous infection history:

SOCIAL HISTORY: _____Married _____Single _____Divorced _____Widowed
If you are a female patient, are you pregnant? _____Yes _____No
Number of children _____ Employed _____Yes _____No

Tobacco Use _____Yes _____No. If yes, frequency (packs a day) _____. If no, have you smoked in the past? _____Yes _____No. If yes, when did you quit? _____

Alcohol Consumption ____Yes _____No. If yes, how frequently _____

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY ON: either prescribed or over the counter including vitamins and herbal supplements:

Name	Dosage	Reason for Use

(please attach an extra sheet if needed for medication use/history)

Do you take aspirin or aspirin products? _____ Yes _____ No. Acetominophen(Tylenol)? ____ Yes ____ No. Ibuprofen (Advil/Motrin)? _____ Yes ____ No. NSAIDs (Aleve)?

Yes	No

Other anti-inflammatory medications?_____

DRUG ALLERGY: Do you have any drug allergies? _____Yes _____No
If yes, please list drugs and reaction:

FOOD ALLERGIES: Do you have any food allergies? _____Yes _____No
If yes, please list foods and reaction:

IMMUNIZATION ALLERGIES: Have you ever had an allergic reaction to any immunizations? _____Yes _____No. If yes, please list:

ENVIRONMENTAL ALLERGIES: Do you have any environmental allergies? ___Yes ____No. If yes, please CIRCLE allergens listed below that effect you:

POLLENS RAGWEED GRASSES ANIMAL DANDER DUST DUST MITES
LATEX IODINE BEES/FLIES SHELLFISH INTRAVENOUS CONTRASTS

Acknowledgement

DATE: _____

I, the undersigned, acknowledge that I have received the following disclosures of the practice:

- Facility information
- Facility Ownership Disclosure
- Patient Bill of Rights
- Health Practice and Privacy Act Information
- Complaint Resolution Policy
- Billing Information / Out of Network Insurance Status (does not apply to 1199 insurance)
- Physician Qualifications

Name: _____

Signature: _____

Reviewed and signed by Dr. Vijay Anand_____

Patient Name:_____
Date:

This is our agreement to the effect that after specialist office visits and/or surgery with Dr. Vijay Anand, that you have not paid for at the time of service, when you receive the insurance company reimbursement check/s, you will directly endorse the back of the insurance check and mail promptly with the appropriate explanation of benefits (EOB) to Dr. Anand. You agree not to deposit such payments into your bank account for the purpose of issuing us your personal or business check, in order to avoid the delays and the inconvenience of further collecting from you.

I understand that my out of network insurance deductible must be collected by law.

I am responsible for any coinsurance balance based on my out of network benefits after insurance payment.

Patient signature:_____

Name _____ Date _____

Sino-Nasal Outcome Test-22 Questionnaire v4

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. We would like to know more about these problems and would appreciate you answering the following question 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.

Considering how severe the problem is when you experience it and how frequently 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
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5
6. Thick nasal discharge	0	1	2	3	4	5
7. Ear fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain/pressure	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Waking up at night	0	1	2	3	4	5
13. Lack of a good night's sleep	0	1	2	3	4	5
14. Waking up tired	0	1	2	3	4	5
15. Fatigue during the day	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5
21. Sense of taste/smell	0	1	2	3	4	5
22. Blockage/congestion of nose	0	1	2	3	4	5
TOTAL:	____	____	____	____	____	____

For Medical Use Only GRAND TOTAL: _____

VISIT: *Pre-op* *3 weeks* *6 weeks* *12 weeks* *6 months* *1 year*

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Tel (212)452-3005 Fax (212)452-3660
Email: vijayanandmd@gmail.com
sinusitis-solutions.com
endoscopicskullbasesurgery.com

Dear Patients,

Our physicians and staff at Vijay Anand M.D., P.C., and East Side Physician Specialist, would like to take this opportunity to welcome you to our office. As your providers of health care, we look forward to serving you. We hope that, together, we can build the kind of relationship that will ensure that you receive quality care and good service.

In order to maximize your health benefits, it is very important that you familiarize yourself with the systems, policies, and protocols outlined in this letter or ask our courteous staff if you have any further questions.

The following is important information you should know:

SCHEDULING APPOINTMENTS

Our appointment desk is available Monday through Friday, from 9am to 5pm daily, 212-452-3005. After office hours, you may call this number and a recording will provide emergency information. Our fax number is 212-452-3660.
Parking garages-73rd Street between 3rd Avenue and Lexington Avenue.

CANCELLATIONS

If you must cancel an appointment, please call the appointment desk AS SOON AS POSSIBLE.

YOU HAVE CERTAIN PATIENT RIGHTS:

1. You have the right to be treated with respect, consideration, and dignity.
2. You have the right to high quality medical care delivered in a safe, timely, efficient and cost effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the fullest extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment, and prognosis.
6. You have the right to the copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages, disadvantages and alternatives to having the procedure performed in the office or other outpatient facility or hospital.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives discussed in #7 above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.

12. You have the right to know the available services at the facility.
13. You have the right to know the provisions for after hours and emergency care.
14. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
15. You have the right to know whether or not your providers are insured.
16. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals in the event you are dissatisfied with your treatment.
17. You have the right to know the name of your provider.
18. You have the right to know what fees are expected and what the payment policies are.
19. You have the right to know what the physician's credentials are.
20. You have the right to change providers at any time.

YOU ALSO HAVE CERTAIN REPONSIBILITIES:

1. You have the right to accurately and completely provide all clinical personnel with the health information they need including any medications you are taking.
2. You have the responsibility to follow directions of the medical assistant or doctor with regard to diet and/or medication. Compliance is important for desired medical results.
3. You have the responsibility to abstain from using any drugs that have not been prescribed for you and that you have not revealed to the medical assistant or physician.
4. You have the responsibility to abstain from alcohol as directed by your medical assistant or physician.
5. You have the responsibility to inform the medical assistant or physician if you do not understand any directions or you do not understand the course of treatment planned for you.
6. You have the responsibility to timely pay all medical bills which are not in dispute and to forward to us any monies you receive for our services from direct insurance company reimbursement along with a copy of the explanation of medical benefits.

COMPLAINT RESOLUTION

We at East Side Physician Specialist strive to provide you with excellent quality care. We strongly believe in changes to improve and welcome an opportunity to listen to your suggestions and complaints. Please contact office administrator, Ms. Shoni Thoulouis, regarding any issues or to get further information on our complaint resolution policy.

Our office is accredited with and follows strict guidelines and standards required by the **Joint Commission**, a governing body to insure quality and safety at medical facilities. If you have any unresolved issues and complaints you can contact the Joint Commission directly:

E-mail: complaint@jcaho.org
Mail: Office of Quality Monitoring
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook, Terrace, IL 60181
Telephone: 800-994-6610
Our JCAHO site name is East Side Physician Specialist.
Our JCAHO reference number is # 431904.

BILLING AND PAYMENT

Please see our front desk or medical biller for details regarding consultation and/or other fees.

INVOLVED IN YOUR HEALTHCARE

Everyone has a role in making healthcare safe. Our physicians, medical assistant, surgical coordinator and office administrator are working to keep your healthcare safety an ultimate priority. You as a patient can play a vital role in keeping your care safe by becoming an active, involved and informed member of the healthcare team. So please, SPEAK UP:

S-Speak up if you have any questions or concerns and if you do not understand, please ask again.
P-Pay attention to the care you are receiving. Make sure you are getting the right treatment and medication.
E-Educate yourself about your diagnosis and your treatment plan.
A-Ask a trusted family member to be your advocate.
K-Know what medications you take and why you take them. Keep a list with you.
U-Use an accredited health facility that provides quality care.
P-Participate in all discussions and decisions about your treatment.

PHYSICIAN INFORMATION

Dr. Anand is Board Certified in Otolaryngology and Head & Neck Surgery.
Becoming a licensed, board certified physician means meeting the most rigorous training and continuing education offered in the field of medicine.

Certification of Physicians is done by Medical Specialty Boards, recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA), as a way to inform consumers that the doctors with these credentials have successfully completed approved training, passed an evaluation process assessing their abilities, and completed required continuing medical education credits yearly. Board certification is time-limited, and to maintain their certification, doctors are periodically reevaluated. They must present evidence of licensure and scope of their practice and pass an examination every 7 to 10 years, depending on their specialty.

FACILITY OWNERSHIP DISCLOSURE

Vijay Anand, M.D., P.C. and East Side Physician Specialist are owned by and operated by Dr. Vijay K. Anand.
Please keep this letter for future reference. Should you have any questions, please feel free to contact us. We look forward to serving you.

Sincerely,

Dr. Vijay K. Anand
CEO / Medical Director