HARVARD MEDICAL SCHOOL MASSACHUSETTS EYE AND EAR INFIRMARY

ERIC H. HOLBROOK, MD

ENDOSCOPIC SINUS AND SKULL BASE SURGERY
243 CHARLES STREET
BOSTON, MA 02114
PHONE: 617-573-3209
FAX: 617-573-6845

Greetings,

You are scheduled for an appointment on _____ at _____ with Dr. Eric Holbrook. Please try to arrive to at least 15 minutes prior to your scheduled time. Our office building is located in a busy high traffic area so please plan your travel accordingly. The clinic is located at 243 Charles St. Boston, MA 02114 on the 9th floor Sinus Center.

What to expect during your first visit:
During your initial visit you will often first see a medical assistant or nurse in order to clarify your medications and review your questionnaires.
After reviewing your records and any imaging you may have had, Dr. Holbrook will discuss your history and proceed with a general head and neck exam. In order to get a comprehensive assessment of your nose and sinuses Dr. Holbrook will then perform a *diagnostic sinonasal endoscopy*. This is a procedure consisting of placing a thin endoscope in the nose in order to examine the entire nasal cavity and sinus drainage pathways. While this procedure is generally painless, the nurse or medical assistant will provide you with a topical anesthetic and decongestant spray to help make you as comfortable as possible.
***Please note that while most insurances cover this procedure, some specific plans require a co-pay. Please check with your insurance company directly to ensure this is a covered benefit under your plan.**

After your visit:
After your exam Dr. Holbrook will review your diagnosis and determine if any additional tests are required and will arrange any treatments and/or follow-up visits.

If you have any prior records which may be relevant please bring them with you during your visit or have them faxed in advance to 617-573-6845. *If you have had any previous CT scans or MRIs of the head or sinuses these are also often very helpful to bring to your consultation*. It is your responsibility to ensure that your paperwork/scans are present at your visit. Please do not solely rely on a referring office to get your paperwork/scans here as they can sometimes be unreliable. If you have any questions or you are late for your appointment, please call the office at 617-573-3209.

Sinus Center- Massachusetts Eye and Ear Infirmary

Massachusetts Eye and Ear

243 Charles Street, Boston, MA 02114 • (617) 523-7900 • MassEyeAndEar.org

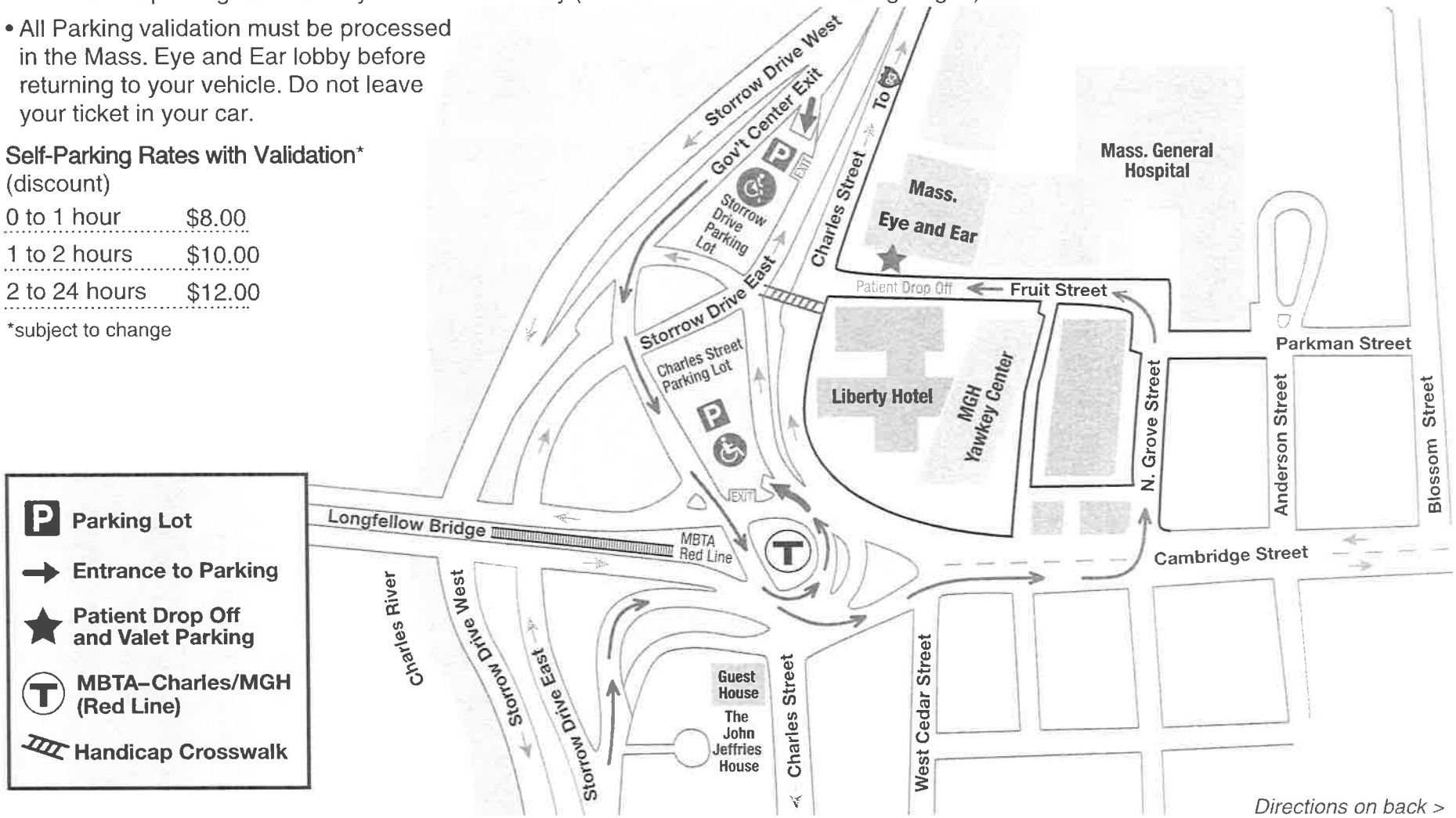
Parking Valet Services

- Valet parking is available at the main entrance on Fruit Street for patients and their visitors for $15.00, Mon. – Fri., 5:30 AM-3:30 PM
- We vaildate parking for Mass. Eye and Ear lots only (We do not validate for MGH garages).
- All Parking validation must be processed in the Mass. Eye and Ear lobby before returning to your vehicle. Do not leave your ticket in your car.

Self-Parking Rates with Validation*
(discount)

0 to 1 hour	$8.00
1 to 2 hours	$10.00
2 to 24 hours	$12.00

*subject to change



Directions on back >

Directions to Massachusetts Eye and Ear

DRIVING DIRECTIONS:

From South

- Follow signs to I-93 North/Boston
- Take exit 26 to Storrow Drive (West)
- Take Government Center/Kendall Square exit

P To NON Handicap Accessible Parking (Storrow Drive Lot):

- Stay in left lane on Storrow Drive (West)
- Entrance to parking lot is immediately before approaching Government Center/ Kendall Square exit ramp

P To Handicap Accessible Parking (Charles Street Lot):

- Proceed through the lights under (T) station; take a hard left reversing direction under the (T) Station
- The Mass. Eye and Ear parking lot is located off the ramp to Storrow Drive (West)

★ Patient Drop Off/Valet

- Turn left onto Cambridge Street
- Take the first left onto N. Grove Street
- Turn left onto Fruit Street. Mass. Eye and Ear will be on your right

DRIVING DIRECTIONS:

From North

- Follow signs to I-93 South/Boston
- Take exit 26 to Storrow Drive (West)
- Take Government Center/Kendall Square exit

P To NON Handicap Accessible Parking (Storrow Drive lot):

- Stay in left lane on Storrow Drive (West)
- Entrance to parking lot is immediately before approaching Government Center/ Kendall Square exit ramp

P To Handicap Accessible Parking (Charles Street Lot):

- Proceed through the lights under (T) station; take a hard left reversing direction under the (T) Station
- The Mass. Eye and Ear parking lot is located off the ramp to Storrow Drive (West

★ Patient Drop Off/Valet

- Turn left onto Cambridge Street
- Take the first left onto N. Grove Street
- Turn left onto Fruit Street. Mass. Eye and Ear will be on your right

DRIVING DIRECTIONS:

From West

- Follow I-90 East (Mass Pike) toward Boston
- Follow to Exit 18 Allston/Cambridge (a left lane exit)
- After toll plaza, bear right following signs for Cambridge
- Keep right, go straight through first traffic light and turn right at second traffic light
- Take Storrow Drive (East) towards downtown Boston
- Take Government Center/Kendall Square exit

P To Handicap Accessible Parking (Charles Street Lot):

- Take hard left under (T) station towards Storrow Drive (West)
- The Mass. Eye and Ear parking lot is located off the ramp to Storrow Drive (West)

Note: Storrow Drive Lot not available from the West.

★ Patient Drop Off/Valet

- Turn right onto Cambridge Street
- Take the first left onto N. Grove Street
- Turn left onto Fruit Street. Mass. Eye and Ear will be on your right

SUBWAY DIRECTIONS (Public Transporation):

From Red Line – Charles/MGH Station Ⓣ

- Take the train to the Charles/MGH Station. Exit the station to the right.
- Cross the street toward the Liberty Hotel (former Charles Street Jail).
- Facing the Liberty Hotel, take the sidewalk to the left.
- Mass. Eye and Ear is located just beyond the hotel.

For Maps and Directions to our other locations, visit our website at MassEyeAndEar.org

See other side for Map >

Massachusetts Eye and Ear

ENDOSCOPIC OFFICE EXAM

What Is It?

Some parts of the nose and throat may be difficult to examine. Endoscopy is recommended to provide the best possible view of your nose, sinuses, throat and/or voice box. In this procedure a local anesthetic and a decongestant may be sprayed in your nose and a slender scope is passed through your nose and/or your throat to check the areas of the nose, larynx and pharynx.

What Are The Advantages?

Endoscopy may cause some mild discomfort but the procedure is quick and highly accurate. It is one of the most accurate ways of checking the nose and throat for any abnormalities. Without endoscopy such a detailed examination would require an exam under general anesthesia.

What Are The Disadvantages?

There are no major risks. There can be slight bleeding, but this is extremely rare.

Does Insurance Cover Endoscopy?

This procedure is usually covered by insurance. Some insurance companies might list this procedure on your statement (Explanation of Benefits) as "surgery" or as a "surgical procedure." If you have any questions about your potential out of pocket expenses, please speak with your insurance company's Member Services to fully understand your financial responsibilities. Alternatives to this procedure include CT, MRI and PET scans as well as examination under anesthesia, all of which are more costly than Endoscopy.

What If I Decide NOT To have the Endoscopy?

Endoscopy is important and without it your doctor may not be able to accurately diagnose an infection, serious condition or, in some cases, even a cancer or some other life-threatening condition.

If you have further questions about the need for endoscopic exam please don't hesitate to ask a member of our clinical team.

Massachusetts Eye and Ear

INFORMATION ABOUT YOUR BILL

To Our Patients:

Thank you for selecting Massachusetts Eye and Ear and our physicians for your health care. This document provides you with information about our registration process and financial issues associated with your care.

This office is a Mass. Eye and Ear, hospital outpatient facility. Insurance coverage and financial responsibility, including copayments, may differ for services provided in an outpatient facility than for services provided in a physician office setting. Please contact your insurance company to fully understand your coverage for services provided in a hospital outpatient facility.

Hospital Outpatient Facility Billing

Hospital outpatient facility billing refers to the billing process for services rendered in a hospital outpatient facility or site. This is the national model of practice for integrated healthcare delivery systems where the hospital owns the space and hospital employees support the personnel involved in patient care.

This model benefits patients as all departments of the hospital are subject to strict quality standards and monitored by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organization and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality which reflects an organization's commitment to meeting certain performance standards.

Because your care is provided in a hospital-based outpatient site, you may receive charges from our physician group, Massachusetts Eye and Ear Associates (MEEA) and from the hospital, Massachusetts Eye and Ear Infirmary (MEEI).

The MEEI portion includes charges for any diagnostic tests that you may have had as well as a facility fee that covers the costs of operating the site. The MEEA portion covers the charges for your physician's professional services.

Before Your Appointment

We recommend checking with your insurance company to ensure that they will pay both Mass. Eye and Ear and the physician for your services, and to understand what your copayment, deductible, and coinsurance costs may be.

If your insurance plan, including Medicare Advantage Plans and Medicaid Managed Care Plans, is not contracted with Mass. Eye and Ear or if Mass. Eye and Ear or your physician are considered "out-of-network" by the plan, your costs may be higher.

If your insurance requires a referral from your Primary Care Physician and it is not in place prior to your appointment, your appointment may need to be rescheduled or you may be asked to sign a payment responsibility waiver when you arrive.

If you are coming in for service that is not covered by your insurance plan, payment is expected prior to, or on, the date of service. If you do not have insurance or are in need of financial assistance, please ask to speak with a Financial Coordinator.

Worker's Compensation or Other Accident

Coverage for these services requires verification. Please bring all documentation related to your case on the day of your appointment.

When You Arrive For Your Services

Please let us know if your personal information or insurance coverage has changed since we last spoke with you.

Collection of copayments is required by your insurance plan. We collect known copayments at the time of service, but because we do not always know all the services you will be receiving, additional copayments may apply. In accordance with your insurance plan, you will be billed for these at a later time.

If You Need Medically Necessary Surgery or Treatment And You Have Insurance ...

Your health plan may require pre-authorization for services. We will contact the plan or your primary care physician to obtain these pre-authorizations.

Since benefit levels vary by plan, it is recommended that you call your health plan to confirm that your surgery will be covered and determine what your out of pocket expenses may be.

If you do not have insurance, you will be given a good faith estimate and access to a Financial Coordinator who can assist you in determining how your surgery may be covered.

If You Choose To Have Non Medically Necessary Surgery or Treatment and You Do Not Have Insurance...

You will be given a good faith estimate and be required to pay in full prior to receiving services.
You should ask to meet with a Financial Coordinator if you think you will need financial assistance.

Additional Information

You are financially responsible for any deductible and/or coinsurance payments imposed by your insurer, and for any services not covered by insurance.

If you do not have insurance or are unable to pay the full amount at the time of service, our Financial Coordinators will work with you to see if you are eligible for any other coverage, or to establish a payment plan.

Payment Options

Mass. Eye and Ear and our physicians accept the following forms of payment for services:
Check, money order and all major credit cards. Wire transfers are also accepted.

You can pay your bills online at http://www.masseyeandear.org/billing

Important Phone Numbers

Pre-Registration	**617-573-4200**	**Financial Coordinators**	**617-573-5664**
Billing	**617-573-3135**		

Massachusetts Eye and Ear complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability. Massachusetts Eye and Ear does not exclude people or treat them differently because of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability.

Massachusetts Eye and Ear Infirmary

A Teaching Hospital of Harvard Medical School

Patient Sticker

Assignment of Insurance Benefits

I request that payment of authorized insurance or Medicare benefits be made on my behalf to Mass Eye and Ear Associates and Mass Eye and Ear Infirmary for services furnished me by Mass Eye and Ear Associates and Mass Eye and Ear Infirmary. I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that if a MediGap policy or other health insurance is indicated on the claim form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mass Eye and Ear Associates and Mass Eye and Ear Infirmary.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

X Patient Signature	

Acknowledgment of Notice of Privacy Practices

I acknowledge that I received the Massachusetts Eye and Ear Infirmary, and Massachusetts Eye and Ear Associates, Inc Notice of Privacy Practices.

X Patient Signature	

For Internal Use Only:
The patient above received the Notice of Privacy Practices and declined to sign this Acknowledgement.

Staff Member Name	
Staff Member Signature	

If patient is a minor or is otherwise unable to sign these Acknowledgments, the signature of a parent, guardian, or other legal representative is required:

☐ Assignment of Insurance Benefits ☐ Acknowledgment of Notice of Privacy Practices

Personal Representative Name	
Personal Representative Signature	
Relationship to Patient	

MASSACHUSETTS EYE AND EAR INFIRMARY

DISCLOSURES TO OTHER HEALTH CARE PROVIDERS FOR COORDINATION OF CARE

Your Mass. Eye and Ear physician will coordinate your care with your other health care providers when he or she feels this would be helpful. He or she will use his or her judgment to determine whether and to which health care providers it is appropriate to provide information about your care.

To make sure that your Mass. Eye and Ear physician has contact information for your other health care providers, please indicate below the names of health care providers, such as your primary care physician or another specialist, to whom you would like your Mass. Eye and Ear physician to provide information about your treatments when he or she thinks this is appropriate.

Mass. Eye and Ear uses an electronic health record called LMR that allows certain other health care providers outside of Mass. Eye and Ear who provide you treatment, and who also use LMR, to "look up" information about your treatment at Mass. Eye and Ear without any action on the part of your Mass. Eye and Ear physician or you.

When your Mass. Eye and Ear physician determines it is appropriate, he or she may send a secure, electronic message through LMR to your health care providers who use LMR. Alternatively, he or she may also provide information to your health care providers who don't use LMR by mail, fax, telephone or secure e-mail.

1. _____
(Name of Physician)

_____
(Street Address)

_____
City, State Zip code

_____ / _____
Phone # Fax#

2. _____
(Name of Physician)

_____
(Street Address)

_____
City, State Zip code

_____ / _____
Phone # Fax#

3. _____
(Name of Physician)

_____
(Street Address)

_____
City, State Zip code

_____ / _____
Phone # Fax#

4. _____
(Name of Physician)

_____
(Street Address)

_____
City, State Zip code

_____ / _____
Phone # Fax#

Patient's Information:

(Place IDX Label Here.)

Patient's Signature: _____

Form Issued 09/24/10

HARVARD MEDICAL SCHOOL — MASSACHUSETTS EYE AND EAR INFIRMARY

SINUS CENTER SINUSITIS INFORMATION FORM

IF YOU ARE BEING SEEN FOR SINUSITIS PLEASE ANSWER THE FOLLOWING QUESTIONS

Name: _____ Date: _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

☐Nasal Drainage	Duration(Months)_____	#Times/year _____
☐Nasal Congestion/Blockage	Duration(Months)_____	#Times/year _____
☐Facial Pain/Pressure or Headache	Duration(Months)_____	#Times/year _____
☐Post Nasal Drip	Duration(Months)_____	#Times/year _____
☐Decreased Smell/Taste	Duration(Months)_____	#Times/year _____

1) HAVE YOU HAD ANY SINUS OR NASAL SURGERY(if yes, when)? _____
2) IN THE PAST YEAR HOW MANY TIMES HAVE YOU BEEN ON ANTIBIOTICS? _____
3) HAVE YOU EVER USED ANY NASAL STEROID SPRAYS(ie. Flonase, Rhinocort, etc..)? _____
4) HAVE YOU BEEN TREATED WITH ORAL STEROIDS IN THE PAST YEAR? _____
5) HAVE YOU EVER BEEN ON ANTIHISTAMINES(ie. Claritin, Allegra, etc..)? _____
6) HAVE YOU EVER BEEN TESTED FOR ALLERGIES? _____
7) IF YES WHAT ARE YOUR ALLERGIES(ie. dust, mold, pollen, etc..)? _____
8) DO YOU HAVE A HISTORY OF ASTHMA? _____
9) DO YOU OR HAVE YOU EVER SMOKED(If yes, how long, packs/day)? _____

Please grade each the following symptoms on a 0-5 scale (0-Not a problem for me; 5-Worst problem possible)

Please "X" your 5 worst symptoms in this column

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. Nasal Obstruction	0	1	2	3	4	5	
5. Loss of Smell or Taste	0	1	2	3	4	5	
6. Cough	0	1	2	3	4	5	
7. Post-Nasal Discharge	0	1	2	3	4	5	
8. Thick Nasal Discharge	0	1	2	3	4	5	
9. Ear Fullness	0	1	2	3	4	5	
10. Dizziness	0	1	2	3	4	5	
11. Ear Pain	0	1	2	3	4	5	
12. Facial Pain/Pressure	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 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	

HARVARD MEDICAL SCHOOL MASSACHUSETTS EYE AND EAR INFIRMARY

SINUS CENTER MEDICAL INFORMATION FORM

Benjamin S. Bleier, MD
Nicolas Y. Busaba, MD
Stacey T. Gray, MD
Eric H. Holbrook, MD

Date: _____

Name: _____ DOB / / Age: _____

Address: _____ City/State/Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Employment: _____

Emergency Contact (Name, Relationship, Phone #): _____

Primary Care Physician(PCP): _____

PCP Address and Phone Number: _____

Were You Referred? YES/NO Name of Referring Physician: _____

Referring Physician(Address, Phone #): _____

WHAT IS YOUR PRESENT PROBLEM? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT TREATMENTS HAVE YOU TRIED? _____

Please answer the following questions and check all that apply:

Do you have any allergies(Medications, Latex, etc..)? _____

What are your current medications?

Do you have a history of:

☐Diabetes	☐Stroke	☐Heart Attack	☐Heart Disease	☐High Blood Pressure
☐Blood Clots	☐Chemotherapy	☐Cancer	☐Radiation	☐Immune Problems
☐Bleeding	☐Ulcer	☐Lung Disease	☐AIDS/HIV	☐Hepatitis

Do you have any other medical problems?

Have you had any surgeries(Please list month/year)?

Please Complete and Sign Reverse Side ⟶

Prior to your *FIRST* sinus infection, did you take antibiotics for any reason *BESIDES* your sinuses(Please circle)?

YES NO N/A

If *YES*, how much time passed between the antibiotics and your first sinus infection(Please circle all that apply)

1-3months 3-6months 6months-1year 1-2years Over 2 years

What was the reason you were given antibiotics? _____

What was the name of the antibiotic? _____

Do you smoke? YES/NO Packs/day? _____ Have you ever smoked? YES/NO

Do you drink alcohol? YES/NO Drinks/week? _____

Have you experienced any of the following?

EYES	☐Blurred Vision ☐Painful Eyes ☐Light Irritation ☐Other
EARS, NOSE, THROAT	☐Blocked Nose ☐Post Nasal Drip ☐Runny Nose ☐Neck Masses ☐Mouth Sores/Pain ☐Difficulty Breathing ☐Difficulty Swallowing ☐Pressure in Ears ☐Ringing in Ears ☐Hearing Loss ☐Vertigo ☐Other
CARDIOVASCULAR(HEART)	☐Palpitations ☐Chest Pain ☐Shortness of Breath ☐Other
RESPIRATORY(LUNGS)	☐Wheezing ☐Shortness of Breath ☐Cough ☐Other
GASTROINTESTINAL	☐Constipation ☐Diarrhea ☐Reflux ☐Other
GENITOURINARY	☐Urinary Hesitancy or Pain ☐Urination at Night ☐Other
MUSCULOSKELETAL	☐Soreness ☐Weakness ☐Cramping ☐Other
SKIN	☐Itching ☐Lesions ☐Rashes ☐Bleeding ☐Other
NEUROLOGICAL	☐Numbness ☐Weakness ☐Dizziness ☐Other
PSYCHIATRIC	☐Mood Swings ☐Anxiety ☐Depression ☐Stress ☐Other
ENDOCRINE	☐Hot Flashes ☐Hair Loss/Growth ☐Heat ☐Cold ☐Other
HEMATOLOGY	☐Night Sweats ☐Bleeding/Bruising ☐Clotting ☐Other
ANESTHESIA	☐Malignant Hyperthermia ☐Nausea ☐Chipped/Loose Teeth ☐Other

Patient Signature _____ Date _____