WELCOME TO THE PRACTICE OF ALLERGY & ASTHMA SPECIALISTS, P.C.

51 Route 23 South
Riverdale, NJ 07457
Ph: (973) 831-5799
Fx: (973) 831-7422

82 East Allendale Road, Suite 7A&B
Saddle River, NJ 07458
Ph: (201) 236-8282
Fx: (201) 236-0138

PATIENT INFORMATION

Patient Name ______________________

Sex: ☐ Male ☐ Female

Patient's DOB ____/____/____ Age ______

Address ______________________

City, State, Zip ______________________

Home Phone: (____) ____________ Cell: (____) ____________

Employer/Occupation ______________________

Work Phone: (____) ____________

Marital Status: ☐ Married ☐ Divorced ☐ Single

Pharmacy Name ______________________

GUARANTOR INFORMATION *(Responsible for any patient balance)*

First Name: ____________ Middle Initial: ___ Last Name: ____________ Mother ☐ Father ☐ Other: ______

Address: ______________________________________

Home Phone: (____) ____________ Work Phone: (____) ____________ Birth Date ___/___/___ SSN: ____________

Sex: ☐ Male ☐ Female Occupation: ____________ Employer Name: ____________

Marital Status: ☐ Married ☐ Divorced ☐ Single

INSURANCE INFORMATION (Person who holds Ins. Plan)

Primary Insurance

Subscriber (name of insured): ________________ Relationship: ______ D.O.B. : ______ SS# ____________

Secondary Insurance

Subscriber (name of insured): ________________ Relationship: ______ D.O.B. : ______ SS# ____________

Primary Doctor (Must be completed)

Primary Physician: ______________________________Phone #: (____) ____________

RELEASE OF INFORMATION

I authorize the release of any information necessary to process insurance claims. I also authorize payment of benefits to Allergy & Asthma Specialists, P.C. I authorize your office to leave messages on my telephone machine/voicemail for numbers listed above.

Signature: ________________ Date:____________

FINANCIAL RESPONSIBILITY

All co-payments are due at time of service. I understand that certain charges may not be covered by my insurance and I am financially responsible for all charges incurred. If a referral is required by my health insurance plan, I understand that the referral must be valid and completed with the provider name. I understand that I will be held responsible for the cost of services provided if I do not present a valid referral. I permit a copy of this release to be used in place of the original.

Signature: ________________ Date:________

Allergy and Asthma Specialists, P.C.

Health Questionnaire

Patient: ______________________ **DOB:** ____________ **Age:** ______ **Date:** ______

Reason for Visit: ____

Medications:

Please list the name and strength of the medications you are currently taking. (For example, Digoxin 0.125 mg.)

Name	Strength (e.g., 10 mg.)	Name	Strength

Drug Allergies:

Please list any drug allergies, including reactions. Please state NONE if no allergies.

Drug	Reaction	Drug	Reaction

Non-Drug Allergies:

Please list any food or non-drug allergies, including reactions. State NONE if no allergies. (For example, Latex, mold, milk, nuts, etc.)

Substance	Reaction	Substance	Reaction

OTC Antihistamines:

Please list any over the counter anti-histamines that you have tried and whether they have helped you.

Name	Helped? Y/N	Name	Helped? Y/N

Past Illnesses

Please circle Y if you have had any of these illnesses in the past.

Asthma	Y	Emphysema	Y	High Blood Cholesterol	Y	Prematurity	Y
Broken Nose	Y	Food Allergy	Y	Hives	Y	Resp Support at Birth	Y
Bronchitis	Y	Frequent Headaches	Y	Hormonal Difficulty	Y	Seasonal Allergies	Y
Croup	Y	Hay Fever	Y	Migraine	Y	Sinus Disease	Y
Deviated Septum	Y	Heart Disease	Y	Nasal Polyps	Y	Skin Disease	Y
Eczema	Y	High Blood Pressure	Y	Nasal Surgery	Y	Stomach Disease	Y
				Overactive Thyroid	Y	Underactive Thyroid	Y

Cancer ____

Please describe type of cancer and treatment you have received. (For example, radiation, chemotherapy, surgery)

Other ____

Previous Surgeries

Please put the date of any of the following past surgeries (MM/YYYY).

Adenoidectomy ____________

Ear (PE) tubes ____________

Septoplasty ____________

Sinus surgery ____________

Tonsils and Adenoids ____________

Please list and date any additional previous surgeries.

Surgery	Month/Year

Height: _____'______

Weight: __________**Lbs**

Allergy and Asthma Specialists,P.C.

Patient ____________________

Family History

Please check if any blood relative has suffered any of the following:

- [ ] Asthma - [ ] Drug Allergy - [ ] Eczema - [ ] Food Allergy - [ ] Frequent Headaches - [ ] Seasonal Allergies

☐ Asthma ☐ Drug Allergy ☐ Eczema ☐ Food Allergy ☐ Frequent Headaches ☐ Seasonal Allergies
☐ Cancer ☐ Diabetes ☐ Heart Attack ☐ High Cholesterol ☐ Hypertension
☐ Kidney Problems ☐ Obesity ☐ Osteoporosis ☐ Respiratory Problems ☐ Stroke

Social History/Allergy

Pets ☐ None ☐ Dog ☐ Cat ☐ Bird ☐ Rodent Other: ____________________

When? ☐ Past ☐ Currently How long has the family had this pet? ____________________

Is/Are this/these pet(s) allowed in the patient's bedroom? ☐ Yes ☐ No

Housing
☐ City ☐ Suburbs ☐ Rural

Dwelling
☐ House ☐ Apartment ☐ Condo

How long has the patient lived at this residence?

__________ Months OR __________ Years

Bedding (What type of bedding does the patient use)

Pillow: ☐ None ☐ Synthetic ☐ Feather ☐ Unknown
Mattress: ☐ Synthetic ☐ Unknown ☐ Feather

Are there hypoallergenic coverings on the bedding? ☐ Yes ☐ No
Does the patient use a down comforter? ☐ Yes ☐ No

Floor Covering

Bedroom: ☐ Area rugs ☐ Ceramic tile ☐ Wall to wall ☐ Wood
House: ☐ Area rugs ☐ Ceramic tile ☐ Wall to wall ☐ Wood

HVAC

Humidifier: ☐ Yes ☐ No Air Conditioning: ☐ Central ☐ Wall ☐ None
Heating: ☐ Forced Air ☐ Radiant ☐ Stove ☐ Unknown

Basement ☐ None ☐ Unfinished ☐ Finished

Is there chronic leakage? ☐ Yes ☐ No

Smoke Exposure
Secondhand smoke ☐ Yes ☐ No
Patient smokes ☐ Yes ☐ No

Employment: ☐ Inside ☐ Outside

Exposure to (check all that apply):

☐ Chemicals ☐ Dusty materials ☐ Building materials ☐ Irritants: ____________________
☐ Allergens ☐ Young children ☐ No irritants / allergens

Symptoms are (better / worse / same) while at work. (circle word that best applies)

Social History

Use of alcohol: ☐ Denies ☐ Social ☐ Moderate ☐ Heavy ☐ Abuse

Caffeine: ☐ Denies ☐ Occasional ☐ Large ☐ Avoids
☐ Coffee ☐ Tea ☐ Caffeinated soft drinks

Allergy and Asthma Specialists, P.C. Patient: ____________________

Review of systems

Please put CHECK MARK if patient has had any of these symptoms.

Constitution

___ Decreased Appetite
___ Chills
___ Failure to thrive
___ Fatigue
___ Fever
___ Night sweats
___ Sleep Problems
___ Weight change

Eyes/Head

___ Itchy Eyes
___ Migraine Headaches
___ Redness of eyes
___ Sinus headaches
___ Tension headaches
___ Swollen Eyes
___ Watery Eyes

ENT

___ Nasal Congestion/Discharge
___ Nose bleeds
___ Ear pain
___ Post Nasal Drip
___ Sneezing
___ Snoring
___ Sore Throat
___ Tinnitus (ringing in ears)

Respiratory

___ Chest Tightness
___ Cough
___ Difficulty Exercising
___ Shortness of breath
___ Sputum production
___ Wheezing

Cardiovascular

___ Edema. (Swelling)
___ Murmurs
___ Palpitations
___ Fainting

Gastrointestinal

___ Abdnominal Pain
___ Constipation
___ Diarrhea
___ Reflux (Heartburn)
___ Nausea
___ Vomiting

Hematology

___ Anemia
___ Bleeding
___ Bruise Easily
___ Swollen Glands

Endocrine

___ Cold Intolerance
___ Heat Intolerance

Musculoskeletal

___ Joint pain
___ Back Pain
___ Muscle Pain
___ Muscle Weakness
___ Osteoporosis
___ Stiffness

Skin

___ Acne
___ Alopecia
___ Contact Dermatitis
___ Eczema
___ Hemangioma
___ Hives/Swelling
___ Rash/Itching
___ Warts

Psychiatry

___ Anxiety
___ Depression
___ Developmental Delays
___ Hyperactive
___ Irritable
___ Mood Swings
___ Stress

Allergy

___ Drug
___ Food
___ Seasonal

Please complete this page for children under the age of 18

Birth History

Birth Weight: _____Lbs. _____ Ozs.

☐ Vaginal delivery ☐ C-section

Premature? Weeks _____

Complications: ____

____

____

Feeding:

☐ Formula only

☐ Breast fed How long? ______________

☐ Transitioned from breast milk with no problems.

☐ Problems transitioning from breast milk:

____

____

Are immunizations up to date? ☐ Yes ☐ No ______________________________

FINANCIAL AGREEMENT

Allergy & Asthma Specialists, P.C. is committed to providing the best possible medical care for you and your children. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

APPOINTMENTS - 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation **fee of $50 for new patients and a fee of $30 for returning patients** may then be added to your account.

CO-PAYMENTS – By law we **MUST** collect your carrier designated copay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit. Should you not pay at time of service and we subsequently send you a statement, an administrative **fee of $20** may be added to your account.

PATIENT ACCOUNTS – You are responsible for the timely payment of your account. All balances are due within 30 days of your first billing. Any patient balance left unpaid after **90 days** without any attempt at resolution will be considered delinquent and will be submitted to a collection agency. If you are having financial difficulties, please speak to our billing office to set up an acceptable payment plan for you. If the account is turned to collection, it may adversely affect your credit rating and you will be additionally responsible for whatever charges we incur.

REFFERALS – If your plan requires a referral from you PCP, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANACIAL WAIVER. It is then your responsibility to provide us with the referral within **48 hours** or you will be personally responsible for that day's services.

SELF-PAY PATIENTS – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Our office will not be involved with separation or divorce disputes.

MEDICARE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance, if you have one.

WE ACCEPT CASH, CHECKS, MASTERCARD,VISA,AMEX OR DISCOVER.

SIGNED_________________________________ DATE__________________

(Patient, or Parent if under 18)

ALLERGY & ASTHMA SPECIALISTS,P.C. SADDLE RIVER/RIVERDALE OFFICES

HIPAA Notice of Privacy Practices

Allergy & Asthma Specialists, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: F9ood and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

82 East Allendale Rd, Suite 7B
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973-831-5799

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________________ Signature_______________________Date______