LOURDES B. deASIS, MD, MPH, FACP, FAAAAI
SHARON YEE, MD, MS

Welcome to **Allergy & Asthma Consultants of Rockland and Bergen, P.C.** Doctor-Patient communication is exceptionally vital for your care and treatment, including the following:

1. At any time, in a **medical emergency, dial 911**.
   Before and after our regularly scheduled hours our phone lines are forwarded to our answering service. Our regular telephone hours for the West Nyack location are Monday, Wednesday, Friday 9 AM-5 PM, Tuesday & Thursday 11 AM-7 PM, and Saturday 8:40 AM-12 PM. Regular phone hours for the Westwood location are Monday 11AM-7PM, Thursday 9AM-5PM, and Friday 9:20AM-5PM. Our service is able to reach us if you need a call back. The emergency room physician is able to reach us if an allergy, asthma or immunology evaluation is needed.

2. For **non-emergent issues**, please call the office at 845-353-9600 during regular telephone hours Monday, Wednesday, Friday 9 AM-5 PM, Tuesday & Thursday 11 AM-7 PM, and Saturday 8:40 AM-12 PM for the West Nyack location or Monday 11AM-7PM, Thursday 9AM-5PM, and Friday 9:20AM-5PM for the Westwood location. A message will be taken and you will receive a return call **within two business days.**

3. For refills of medications, you should call the office and select the prompt for the prescription line. **It is your responsibility to allow sufficient time for the prescription to be called in or mailed.** Messages are taken off of the prescription line daily during regular telephone hours. Your request will be **addressed within two business days.**

4. If, after regular hours, a problem should arise that cannot wait until the next office day, call the office number at 845-353-9600/201-666-8500 and speak with our service who will be able to reach us. Once again, if it is a **medical emergency, always call 911.**

5. Please remember to keep all scheduled consultations and follow-up appointments. If for some reason you need to cancel or change a scheduled appointment, kindly give us 48 hours notice either by telephone or email to appointments@rballergy.com. Keeping scheduled appointments is important to ensure your continuous care in our office. By telling us in a timely manner that you cannot keep an appointment, we can offer your appointment to someone else. This helps us to reduce waiting times and means everyone can be seen sooner. **If you cancel your appointment less than 24 hours of your scheduled appointment time, or fail to show up for your scheduled appointment, you will be charged either a $50.00 cancellation/no-show fee for consultations and follow-up appointments, or a $100.00 cancellation/no-show fee if your appointment was for an Aspirin Desensitization consultation or Oral Challenge/Desensitization.**

6. Please remember to bring your insurance card(s), photo identification, and any referrals with you to your scheduled appointments as we cannot see you if you do not have the appropriate paperwork, therefore, delaying your continued care. **Remember it is always the patient's responsibility to provide a valid referral should one be required by their insurance plan. Patient's with an insurance deductible higher than $200 will be required to provide a credit card to keep on-file as a form of security.**

7. **To ensure confidentiality and privacy, any type of electronic and video recording, picture taking, and use of cell phones or smart phones is strictly prohibited at any location within the Allergy & Asthma Consultants property.**

I have read the above and I understand the appropriate procedures and communication with Allergy & Asthma Consultants of Rockland and Bergen, P.C.

______________________________ ____________________

Patient Signature Date

2 Crosfield Ave., Suite 406, West Nyack, NY 10994 – Tel: (845) 353-9600 – Fax: (845) 353-9353
354 Old Hook Rd., Suite 207, Westwood, NJ 07675 – Tel: (201) 666-8500 – Fax: (201) 666-5241
www.rballergy.com

PATIENT DEMOGRAPHIC INFORMATION

Last Name ________________________________ **First Name** _______________________ **MI**____

Address ____

City _____________________________________ **State** _________ **Zip Code** ___________________

Birth Date _________________________ **Social Security Number** ___________________________

Race: White☐ Asian☐ Black/AfricanAmr☐ NativeAm/Alaskan☐ NativeHawaii/PacificIsland☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Dominican ☐ Decline to Specify ☐

Marital Status: ____________________________ **Language:** _________________________

Home Phone#: ____________________________ **Cell Phone#:** ______________________________

Email Address: ____

Occupation: _______________________________ **Work Phone#:** ____________________________

Referring Dr: ______________________________ **Primary Care Dr:** _________________________

Emergency Contact Name: __________________________ **Relation:** _________________________

Emergency Contact Phone#: ________________________

INSURANCE INFORMATION

Primary	Secondary
Insurance Company:	
ID #:	
Group #:	
Start Date:	
Are you the Policy Holder?	
If no, Policy Holder's Name	
Relation to Policy Holder:	
Policy Holders Address:	
Policy Holder's Relationship to Patient:	
Policy Holder's D.O.B.	
Policy Holder's SSN:	
Policy Holder's Employer:	
Policy Holder's Phone:	

I hereby authorize release of any information required to process insurance claims related to services rendered by this office.

**** Signature:** ____ **Date:** ______________________

Patient Name **Date**

Please provide us with the information below if you would like us to communicate with your primary care physician, referring physician or any other doctor in regards to your case. We thank you in advance.

Physician's Name

Address
City, State, Zip

Phone

Fax

NPI #

Physician's Name

Address
City, State, Zip

Phone

Fax

NPI #

PATIENT INSURANCE WAIVER

I, ____, have requested treatment from the Allergy & Asthma Consultants. I agree that I am responsible for all charges incurred for any visit. I understand I will be responsible for payment <u>if</u>:

- I am not insured with a participating insurance plan
- There are any fees due to an uncovered/not yet reached deductible
- I do not provide the necessary insurance referral from my PCP on the day of my visit, if required by my insurance plan
- I do not provide the correct insurance information to the office
- My insurance plan has been canceled
- My insurance does not cover the services rendered
- I don't comply with my insurance company request for information (i.e., full time student status, other insurance information)

I am aware that some insurance companies might not cover certain procedures and, in such instance, I will be responsible for the charge associated with the non-covered service. I hereby authorize payment for all medical benefits directly to Allergy & Asthma Consultants of Rockland & Bergen P.C. (P.A.).

Patient Signature___________________________ DATE______________

<u>Authorization of Payment by Credit Card</u>

PLEASE NOTE: A credit card is required on file for all patients with a deductible as a security precaution. You may choose an alternate form of payment at the time payment is due.

- ☐ Visa: Account # ____________________________ Security Code ________
- ☐ Mastercard: Account # _________________________ Security Code ________
- ☐ American Express # ___________________________ Security Code ________

Exp. Date: _____________ Signature: ______________________________

AUTOPAY ELECTION – Save time, postage and paper! ☐

I hereby elect to authorize payment of my deductibles, co-insurance and/or copayment balances to be automatically debited from my account when necessary.

ACKNOWLEDGEMENT

I, _________________________ (patient), acknowledge that I have received a copy of Allergy and Asthma Consultants of Rockland and Bergen's Notice Regarding Privacy of Personal Health Information.

Please give us the names of people/family members whom we may discuss/release any laboratory or test results with:

1.______________________________ Relationship _______________________

2. ______________________________Relationship _______________________

3. ______________________________Relationship _______________________

______________________________ ___________________________

Signature **Date**

Notice Regarding Privacy of Personal Health Information

NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION FOR ALLERGY & ASTHMA CONSULTANTS OF ROCKLAND AND BERGEN ("THE PRACTICE")

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.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that the practice provide you with this Notice Regarding Privacy of Personal Health Information which describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practice's duty to protect this information.

I. Protected Health Information
"Protected Health Information" is health information created or received by your healthcare provider that contains information that may be used to identify you such as demographic data. It includes written or oral health information that relates to you past, present, or future physical or mental health; the provision of healthcare to you; and your past, present, or future payment of healthcare.

II. The Use and Disclosure of Protected Health Information in Treatment, Payment, and Healthcare Operations
Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting healthcare operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclosure your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations permit use or disclosure.

Treatment: The practice may use and disclose you protected health information in the course of providing or managing your healthcare as well as any related services; for the purpose of treatment, or to coordinate your healthcare with a third party. For example, the practice may disclose your protected health information to a pharmacy to fulfill a prescription for asthma medication, to an x-ray facility to order and x-ray, or to a physician who is administering your allergy shots, which we prepared. In addition, the practice may disclose protected health information to other physicians or healthcare providers for treatment activities of those other providers.

Payment: When needed, the practice will use or disclose your protected health information to obtain payment for its services. Such uses or disclosures to your health insurer to obtain approval for recommended treatment or to determine whether you are eligible for benefits or whether or a particular service is covered under your health plan. When obtaining payment for your healthcare, the practice may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, the practice may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: The practice may use or disclose your protected health information when needed for the practice's healthcare operations for the purpose of management or administration of the practice and of offering quality healthcare services. Healthcare operations may include (1) quality evaluations and improvement activities (2) employee review activities and training programs (3) accreditation, certification, licensing, or credentialing activities (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs, and (5) business management and general administrative activities. For instance, the practice may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding allergy care or treatment. In addition, the practice may disclose your protected health information to another provider or health plan for their healthcare operations.

Other Uses and Disclosures: As part of treatment, payment, and healthcare operations, the practice may also use or disclose your protected health information to (1) remind you or an appointment including the leaving of appointment reminder information on your telephone answering machine (2) inform you of potential treatment alternatives or options, or (3) inform your of health-related benefits or services that may be of interest to you.

Additional Uses and Disclosures Permitted Without Authorization or an Opportunity to Object: In addition to treatment, payment, and healthcare operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including (1) when legally required. The practice will comply with any federal, state, or local law that requires it to disclose your protected health information (2) when there are risks to public health. The practice may disclose your protected health information for public health purposes, including to, as permitted or required by law (a) prevent, control, or report disease, injury or disability; (b) report vital events such as birth or death; (c) conduct public health surveillance, investigations, and interventions; (d) collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements, and conduct post marketing surveillance; (e) notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease; and (f) report to an employer information about an individual who is a member of their workforce. (3) To report abuse, neglect, or domestic violence. As required by law or with the patient's agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect, or domestic violence (4) to conduct health oversight activities. The practice may disclose your protected health information to a health oversight agency for use in (a) audits; (b) civil, administrative, or criminal investigations, proceedings or action; (c) inspections; (d) licensure or disciplinary actions; or (e) other necessary oversight activities as permitted by law. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your receipt of healthcare or public benefits. (5) For judicial and administrative proceedings. The practice may disclose your protected health information for any judicial or administrative proceeding if the disclosure is expressly authorized by an order of a court or administrative tribunal is expressly authorized by such order or a signed authorization is provided (6) for law enforcement purposes. The practice may disclose your protected health information to a law enforcement official for law enforcement purposes when (a) required by law to report of certain type of physical injuries; (b) required by court-ordered warrant, subpoena, summons, or similar process; (c) needed to identify or locate a suspect, fugitive, material witness, or missing person; (d) needed to report a crime in an emergency situation; (e) you are the victim of a crime in specific limited instances; and (f) your death is suspected by the practice to be the result of criminal conduct. (7) To coroner, funeral directors, and for organ donations. The practice may disclose protected health information to a coroner or medical examiner for the purpose of (a) identification, (b) determination of cause of death, (c) performance of the coroner or medical examiner's other duties as authorized by law. In addition, as permitted by law, the practice may disclose protected health information, including when death is reasonably anticipated, to funeral director to enable funeral director to carry out his or her duties. Protected health information may also be used and disclosed for the purpose of cadaveric organ, eye, or tissue donation. (8) For research purposes. The practice may use or disclose your protected health information for research if such use or disclosure has been approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information. (9) To prevent or diminish a serious and imminent threat to health or safety. If in good faith he practice believes that use or disclosure of your protected health information is necessary to prevent or diminish a serious and imminent threat to your health or safety or to the health and safety of the public, the practice may use or disclose your protected health information as permitted under the law and consistent with ethical standards of conduct. (10) For specified government functions. As authorized by the HIPAA privacy regulations, the practice may use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations. (11) For worker's compensation. The practice may disclose your protected health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted with an Opportunity to Object
Subject to your objection, the practice may disclose your protected health information (1 to a family member or close personal friend if the disclosure is directly relevant to the person's involvement in your care or payment related to your care; or (2) when attempting to locate or notify family members or others involved in your care to inform them of your location, conditions, or death. The practice will inform you orally or in writing of such uses and disclosures of your protected health information as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosures can be oral or in writing. If you do not object to the disclosures, the practice is able to infer from the circumstances that you do not object, or the practice determines, in its professional judgment, that it is in your best interests for the practice to disclose information that is directly relevant to the person's involvement with your care then the practice may disclose your protected health information. If you are incapacitated or in an emergency situation, the practice may exercise its professional judgment to determine if the disclosure is in your best interests and, if such a determination is made, may only disclose information directly relevant to your healthcare.

IV. Uses and Disclosures Authorized by You
Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

V. Your Rights
You have certain right regarding your protected health information under the HIPAA privacy regulations. These rights include:

1. *The right to inspect and copy your protected health information.* For as long as the practice holds your protected health information, you may inspect and obtain a copy of such information included in a designated record set. A "designated record set" contains medical and billing records as well as any other records that your physician and the practice uses to make decisions regarding the services provided to you. The practice may deny your request to inspect or copy your protected health information if the practice determines in its professional judgment that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referred to in the information. You have the right to request a review of this decision. In addition, you may not inspect or copy certain records by law, including (a) information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceedings and (2) protected health information that is subject to a law that prohibits access to protected health information. You may have the right to have a decision to deny access reviewed in some situations. You must submit a written request to the practice's Privacy Officer to inspect and copy your health information. The practice may charge you a fee for the costs of copying, mailing, or other costs incurred by the practice in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.
2. *The right to request a restriction on uses and disclosures of your protected health information.* You may request that the practice not use or disclose specific sections of your protected health information for the purposes of treatment, payment, or healthcare operations. Additionally, you may request that the practice not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this notice. In your request, you must specify the scope of restriction requested as well as the individuals for which you want the restriction to apply. Your request should be directed to the practice's Privacy Officer. The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment. The practice may terminate the agreement to a restriction in some instances.
3. *The right to request to receive confidential communications from the practice by alternative means or at an alternative location.* You have the right to request that the practice communicates with you through alternative means or at an alternative location. The practice will make every effort to comply with reasonable requests. However, the practice may condition its compliance by asking you for information regarding the procurement of payment or specific information regarding an alternative address or other method of contact. You are not required to provide an explanation for your request. Requests should be made in writing to the practice's Privacy Officer.
4. *The right to request an amendment of your protected health information.* During the time that the practice holds your protected health information, you may request an amendment of your information in a designated record set. The practice may deny your request in some instances. However, should the practice deny your request for amendment, you have the right to file a statement of disagreement with the practice. In turn, the practice may develop a rebuttal to your statement. If it does so, the practice will provide you with a copy of the rebuttal. Requests for amendment must be submitted in writing to the practice's Privacy Officer. Your written request must supply a reason to support the requested amendments.
5. *The right to request an accounting of certain disclosures.* You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment, or healthcare operations as described by this notice. The practice is not required to account for disclosures (a) which you requested, (b) which you authorized by signing an authorization form, (c) for a facility directory, (d) to friends or family members involved in your care, and (e) certain other disclosures the practice is permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer and should state the time period for which you wish the accounting include up to a six-year period. The practice is not required to provide an accounting for disclosures that take place prior to April 14, 2003. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accountings may require a fee based on the practice's reasonable costs for compliance of the request.
6. *The right to obtain a paper copy of this notice.* The practice will provide a separate paper copy of this notice upon request even if you have already been given a copy of it or have agreed to review it electronically.

VI. The Practice's Duties
The practice is required to ensure the privacy of your health information and to provide you with this notice of your rights and the practice's duties and procedures regarding your privacy. The practice must abide by the terms of this notice, as may be amended periodically. The practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that the practice collects and maintains. If the practice alters this notice, the practice will provide a copy of the revised change through regular mail, e-mail, or in person.

VII. Complaints
If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. The practice encourages you to relate any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person
The practice's contact person regarding the practice's duties and your rights under the HIPAA privacy regulations is the Privacy Officer. The Privacy Officer can provide information regarding issues related to this notice by request. Complaints to the practice should be directed to the Privacy Officer at the following address:

Allergy & Asthma Consultants of Rockland and Bergen
ATTN: Privacy Officer
2 Crosfield Avenue, Suite 406
West Nyack, NY 10994
The Privacy Officer can be contacted by telephone at (845) 353-9600 or at (201) 666-8500.

X. Effective Date This notice is effective on April 14, 2003.

Payment Policy

Thank you for choosing Allergy and Asthma Consultants of Rockland & Bergen (AACRB). We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.
Our goal is to provide you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, please ask to speak with one of our billing specialists to discuss other payment options. If you are insured by a plan we participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 30 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or by notifying us at least 24 hours prior to your appointment if you need to reschedule.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

How May I Pay?
We accept payment by cash, check, and all major credit cards.

Do I Need A Referral or Pre-certification?
If your insurance plan requires a referral authorization from your primary care physician or a pre-certification from your insurance, you need to contact your primary care physician or insurance company to be sure it

has been obtained. <u>If we have not received an authorization prior to your arrival at the office your appointment will be rescheduled.</u>

Which Plans Do You Contract With?
AACRB accepts most major insurance plans. Please ask our front desk for a list of plans we participate with. It is always best for you to contact your insurance company prior to your appointment to confirm that we participate with your specific insurance plan.

What Is My Financial Responsibility for Services?
It is your responsibility to provide us with accurate information to enable us to process your claim correctly, which includes up-to-date personal information regarding ALL applicable insurances.
It is your responsibility to verify that the physicians and/or facility in which you are seeking treatment are an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.
Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our practice by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.Do not assume that you will not owe anything if you have more than one insurance policy.

What If I Have Billing or Insurance Questions?
AACRB is supported by a staff of dedicated professionals. Our office staff has the expertise to assist in all financial matters, relieving the patient of burdensome paperwork.

Your financial responsibility depends on a variety of factors, explained below:

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all deductibles, office visits, allergy testing, injections, desensitization, and other charges at the time of office visit.	Accept your initial payment and file an insurance claim as a courtesy to you. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any deductibles and unpaid balances by your plan.
HMO & PPO plans with which we participate	<u>If the services you receive are covered by the plan</u>: All applicable copays and deductibles are requested at the time of the office visit. <u>If the services you receive are not covered by the plan</u>: Payment in full is requested at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
HMO with which we <u>do not participate.</u>	Payment in full for office visits, testing, desensitization, injections, and other charges at the time of office visit.	Accept your payment in full and file an insurance claim as a courtesy to you.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Accept your initial payment and file an insurance claim as a courtesy to you.
Medicare	If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit after your Medicare deductible has been met. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% copay is requested at the time of the visit.	Accept your Medicare deductible (if applicable) and file the claim on your behalf, as well as any claims to your secondary insurance.

If You Have...	You Are Responsible For...	Our Staff Will...
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	Accept your initial payment and file an insurance claim as a courtesy to you.

Testing/ Desensitization

If your physician recommends extensive allergy testing and/or desensitization, this will be scheduled by our nursing coordinator. She will answer specific questions about the procedure, scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Billing Department will require a deposit in the amount of $500.00 to go towards your co-payment, deductible or any other amount deemed the patient's responsibility by your insurance carrier. After your insurance company has processed your claim, any amount remaining as a credit balance will be refunded to you.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors (under 18) on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

What if I missed my appointment to see the Physician?

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours before your appointment to have it rescheduled.

Our highly skilled Physicians are committed to your wellbeing and have reserved time just for you. Patients that miss more than one appointment, without notifying our office 24 hours prior to the scheduled appointment, are subject to a $50.00 missed appointment fee.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above Payment Policy and agree to abide by its guidelines. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service, are my responsibility.

I authorize Allergy and Asthma Consultants of Rockland & Bergen to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Allergy and Asthma Consultants of Rockland & Bergen.

____ _______________
Signature Date

____
Printed Name

Name ____ DOB __________________ Date __________________

I. Describe briefly in your own words the main reason that you are seeking consultation at our office:

____

____

II. Please put a check and complete the blanks which apply to your symptoms:

	Present Problem	**Past Problem**	**Not a Problem**
A. Eye symptoms (Wears contact lenses ☐)			
Itching	☐	☐	☐
Watering	☐	☐	☐
Redness	☐	☐	☐
Swelling	☐	☐	☐
Burning	☐	☐	☐
Dryness	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
B. Symptoms in the upper respiratory tract (nose, sinuses, throat, Eustachian tubes, voice box):			
Itching	☐	☐	☐
Sneezing	☐	☐	☐
Congestion	☐	☐	☐
Headache	☐	☐	☐
Obstruction	☐	☐	☐
Drainage	☐	☐	☐
Soreness	☐	☐	☐
Dryness	☐	☐	☐
Hoarseness	☐	☐	☐
Hearing Loss	☐	☐	☐
Polyps	☐	☐	☐
Impaired Smell/Taste	☐	☐	☐
Snoring	☐	☐	☐
C. Symptoms in the lower respiratory tract (windpipe, bronchi, lungs):			
Itching	☐	☐	☐
Coughing	☐	☐	☐
Sputum Production	☐	☐	☐
Tightness-Congestion	☐	☐	☐
Wheezing	☐	☐	☐
Shortness of Breath	☐	☐	☐
Pain	☐	☐	☐
D. Symptoms in the stomach and digestive system which you suspect might be allergic:			
Pain/Difficulty Swallowing	☐	☐	☐
Nausea or Vomiting	☐	☐	☐
Heartburn/Indigestion	☐	☐	☐
Abdominal Cramping	☐	☐	☐
Constipation/Diarrhea	☐	☐	☐
E. Hives/Giant Swelling	☐	☐	☐
F. Eczema	☐	☐	☐
G. Skin reaction to poison ivy/oak metals, chemicals, or cosmetics	☐	☐	☐
H. Reaction to Food(s)	☐	☐	☐

____

____

____

		Present Problem	Past Problem	Not a Problem
I.	Reaction to bee, hornet, wasp, yellow jacket, other stinging insect	☐	☐	☐
J.	Reaction to Immunization	☐	☐	☐
K.	Latex reaction (gloves, balloons, etc.)	☐	☐	☐
L.	Problems with Immune System (Frequent/Serious Infection)	☐	☐	☐

III. Medical History

A. Childhood Medical History (**If you are 18+ years you may SKIP to section III B**)

- ☐ Full-term
- ☐ Premature
- ☐ Developmental delays
- ☐ Intolerance to milk supplement
- ☐ Intolerance to food
- ☐ Speech & hearing delays
- ☐ **NONE**
- ☐ Other: ____________________

B. Medical Problems:

- ☐ Arthritis
- ☐ Anemia
- ☐ Depression/Anxiety
- ☐ Emphysema
- ☐ COPD
- ☐ Pneumonia
- ☐ Thyroid (Hypo, Hyper, Graves, Hashimotos Nodules
- ☐ Eczema
- ☐ Diabetes
- ☐ Hyperlipidemia
- ☐ Hyperlipidemia (elevated cholesterol/triglycerides)
- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ Arrhythmias
- ☐ Gastroesophageal reflux
- ☐ Hiatal hernia
- ☐ Peptic ulcer
- ☐ Gastritis
- ☐ Low bone density/Osteoporosis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Immune deficiency
- ☐ Autoimmune disease (Lupus, RA, Sjogrens)
- ☐ Migraine
- ☐ Prostate problems
- ☐ Oncological problems (Cancers): ____________
- ☐ Other diseases: ____________
- ☐ **NONE**

IV. Review of Systems (Indicate if you are CURRENTLY experiencing any of the following):

General
- ☐ Fatigue
- ☐ Anemia
- ☐ Fainting
- ☐ Night Sweats
- ☐ Low-grade fever
- ☐ Dizziness
- ☐ **NONE**

HEENT
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Tonsillitis
- ☐ Swollen glands
- ☐ Blurred vision
- ☐ Ear infection
- ☐ Nosebleeds
- ☐ **NONE**

Respiratory
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Chest tightness
- ☐ Coughing
- ☐ Wheezing
- ☐ Coughing blood
- ☐ **NONE**

Cardiovascular
- ☐ Chest pain
- ☐ Palpitation
- ☐ Edema (swelling) of the legs
- ☐ Night coughs
- ☐ Irregular heartbeat
- ☐ **NONE**

G.I.
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ **NONE**

G.U.
- ☐ Urinary Tract Infection
- ☐ Bladder
- ☐ Kidney Infection
- ☐ **NONE**

Musculoskeletal
- ☐ Arthritis
- ☐ Joint swelling
- ☐ Back pain
- ☐ Stiffness
- ☐ **NONE**

Central Nervous System
- ☐ Migraine headache
- ☐ Seizure
- ☐ Numbness
- ☐ Tingling
- ☐ **NONE**

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Unusual thoughts/behavior
- ☐ **NONE**

Skin
- ☐ Easy bruising
- ☐ Hives
- ☐ Skin infections
- ☐ Eczema
- ☐ **NONE**

V. Please list all current medications and dosages (attach another page if necessary)**:**

Pharmacy Name:	**Phone Number:**	
Medication Name	**Dosage**	**Frequency**

VI. Medication Allergies & Intolerances:

☐ **NO KNOWN MEDICATION ALLERGIES OR INTOLERANCES**

Please list any known medication allergies or intolerances

Medication Name	**Date of Reaction**	**Type of Reaction**

VII. Family Medical History

	Father	Mother	Sibling	Paternal Grandparents	Maternal Grandparents	**NONE**
Asthma						
Rhinitis/ Hay fever						
Dermatitis (Eczema)						
Autoimmune Disease						

VIII. Social History

1. Alcohol use:
   - ☐ Yes (how long: ____________)
   - ☐ No
2. Living Will
   - ☐ Yes (details: ______________)
   - ☐ No
3. Persons living at home:
   - ☐ Yes (details: ______________)
   - ☐ No
4. Illicit drug use:
   - ☐ Yes (which drugs: _________________)
   - ☐ No
5. Power of attorney:
   - ☐ Yes (details: ______________________)
   - ☐ No

IX. Smoking History (check only one):

- ☐ Current every day smoker — **Individual who has smoked at least 100 cigarettes during their lifetime and still regularly smokes every day*
- ☐ Current some day smoker — **Individual who has smoked at least 100 cigarettes during their lifetime and still regularly smokes periodically, yet consistent*
- ☐ Former smoker — **Individual who has smoked at least 100 cigarettes during their lifetime but does not currently smoke*
- ☐ Never smoker — **Individual who has not smoked 100 or more cigarettes during their lifetime*
- ☐ Smoker, current status unknown — **Individual who was known to have smoked at least 100 cigarettes in the past, but whether they currently still smoke is unknown*
- ☐ Unknown if ever smoked

☐ ***Smokers in residence?***

X. Environmental History

Residence location:	☐ Suburban	☐ Urban	☐ Rural	
Type of residence:	☐ House	☐ Apartment	☐ Other	
Basement:	☐ No	☐ Yes (Damp __ Dry __)		
Air conditioner:	☐ Central	☐ Window/wall unit	☐ Dehumidifier	☐ Humidifier
Heating System:	☐ Forced Air	☐ Radiator/baseboard	☐ Space heater	☐ Fireplace/wood
	☐ Stove/Furnace	Filter changed every _______ months		
Type of flooring:	Living Area:	☐ Carpet ☐ Wood	☐ Vinyl	☐ Other _________
	Bedroom:	☐ Carpet ☐ Wood	☐ Vinyl	☐ Other _________
Type of bed:	☐ Waterbed	☐ Box-spring	☐ Conventional mattress	☐ Allergy encasement
Type of pillow:	☐ Feather	☐ Foam	☐ Polyester/Dacron	☐ Allergy encasement

Pets:

☐ **NONE**			
☐ Dog	☐ Outdoor	☐ Indoor	☐ Bedroom
☐ Cat	☐ Outdoor	☐ Indoor	☐ Bedroom
☐ Bird	☐ Outdoor	☐ Indoor	☐ Bedroom
☐ Other: ___________________	☐ Outdoor	☐ Indoor	☐ Bedroom

XI. Occupational History

Current occupation ____

Any current exposure to occupational antigens/ irritants (dust, mold, animals, grass, pollen, paint fumes, chemicals, VOCs, pollutants, smoke)? ☐Yes (details: ____________________) ☐No

Previous exposure to occupational antigens/irritants? ☐Yes (details: ____________________) ☐No

XII. Immunization Status (vaccines)

Date of last Influenza vaccine (flu shot): ____________________ ☐ Unknown

Date of last Pneumonia vaccine: ___________________________ ☐ Unknown

Signature: ____ Date: ___________________

PATIENT INSTRUCTION SHEET FOR ALLERGY SKIN TESTING

Please Note: These instructions are in case of testing at any time. Skin Testing is not guaranteed to be done at the first consultation appointment.

You may be skin tested to important local airborne allergens, food allergens, and insect or drug allergens. The skin tests generally take approximately 60 minutes. Skin prick tests will be performed on your back and intradermal tests may be performed on your arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy hive (caused by histamine release into the skin) will appear on your skin within 15-20 minutes. These positive reactions will gradually disappear over a period of 30-60 minutes, and typically, no treatment is necessary for this itchiness. Local swelling at a test site (which itches occasionally) begins 4-8 hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be measured and reported to your physician at your next visit. If they are bothersome, please call the office for instructions on local treatment.

DO NOT:

1. Antihistamines should not be used prior to the scheduled skin testing. Refer to the table on the next page for specific medication and withholding time. These include cold tablets, sinus tablets, hay fever medications, or treatment for itchy skin. Some of the names of these drugs include: Allegra, Clarinex, Claritin, Zyrtec, Xyzal, Actifed, Drixoral, Dimetapp, Benadryl, Tavist, Trinalin, Periactin, Tylenol PM or Tylenol PM Allergy Sinus medications stating PM and many others. If you have any questions, whether or not you are using an antihistamine, please ask the nurse or doctor.
2. Medications such as over-the-counter sleeping medications (e.g. Nytol) and other prescribed drugs such as amityptyline hydrochloride (Elavil), hydroxyzine (Atarax/Vistaril), doxepin (Sinequan) and imipramine (Tofranil) have antihistamine activity and should be discontinued at least **two weeks prior** to skin tests.
3. Patients on Astelin, Astepro (azelastine), or Patanase nasal spray should not use this medication for 48 hours prior to the tests.

YOU MAY:

1. Continue on the following allergy spray: Flonase (fluticasone), Veramyst, Omnaris, Rhinocort, Nasonex,Nasacort, or Nasalcrom.
2. Most drugs do not interfere with skin testing but make certain that your physician or nurse knows about every drug you are taking.

After skin testing, you will meet with the doctor (either the same day or possibly another day) who will make further recommendations regarding your treatment.

**We request that you do not bring small children with you when you are scheduled for skin testing, unless they are accompanied by another adult who can sit with them in the waiting room. Please do not cancel your appointment since the time set aside for your skin test is exclusively yours. If for any reason you need to change your appointment, please give us at least 48 hours notice. Due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized. We thank you for your cooperation. **

EFFECTS OF ANTIHISTAMINES ON ALLERGY SKIN TESTS

(Please Note: These instructions are in case of testing at any time. Skin Testing is not guaranteed to be done at the first consultation)

Antihistamines taken orally (or intranasally) can block response to immediate-type allergy tests. Below is a list of some commonly used antihistamines and approximate amount of time that these medications must be withheld prior to immediate hypersensitivity allergy skin tests. **Please check with your prescribing physician before discontinuing any medication**:

MEDICATIONS	AMOUNT OF TIME
1. Benadryl (Diphenhydramine)	24-48 hours
2. Tylenol Allergy & Sinus or PM (all “PM” products)	24-48 hours
3. Chlortrimeton (chlorpheniramine short-act) 4mg	24-48 hours
4. Astelin, Astepro (azalastine), or Patanase Nasal Spray	48 hours
5. Allegra (fexofenadine) 60mg/Allegra D-12 hour	3 days
6. Periactin (cyproheptadine)	3 days
7. Chlortrimeton 12mg (12 hour)	3-4 days
8. Zyrtec (cetrizine)	3 days
9. Tavist (clemastine)	4 days
10. Allegra (fexofenadine) 180mg	4 days
11. Claritin D-12 hour	7 days
12. Clarinex 5mg	6 days
13. Xyzal (levocetrizine)	7 days
14. Claritin/ Claritin D-24/Alavert/Loratadine	10 days
15. Benzodiazepines (clonazepam, diazepam, lorazepam, midolizam)	5-7 days
16. Atypical antidepressants/ Sedatives (remeron, seroquel)	5-7 days
17. Atarax/Vistaril (Hydroxyzine)	10 days
18. Tricyclic antidepressants (Elavil, Amitryptiline, Nortriptyline)	10-14 days

For information on other antihistamines or medications, please contact our office.