ALLERGY AND ASTHMA COMPREHENSIVE CARE

PATIENT: _____DOB:_____ DATE:_____

Street Address: _____City/Town: _____ State: _____ Zip_____

Home Phone: _____Cell Phone: _____Email:_____

How would you prefer we contact you? (Circle one) Home Phone Cell Phone Email No Preference

Primary physician: _____ Preferred Pharmacy (Name/Town):_____

How did you hear about us?:_____

Insurance Information (please fill out completely):

Insurance company and plan type: _____

Subscriber Name: _____ Relation to patient: _____

Date of birth: _____ Social Security #: _____ID#: _____ID#: _____

Secondary insurance company and plan type: _____

Subscriber Name: _____ Relation to patient: _____

Date of birth: _____ Social Security #: _____ID#: _____ID#: _____

Guarantor (person financially responsible) for patient's account *(if different from above):*

Name: _____ Relation to patient: _____DOB:_____

Address: _____ Phone: _____ SSN: _____

I have received or have been given the opportunity to have/read Allergy and Asthma Comprehensive Care's Financial Agreement. It can also be accessed on our website at njallergycare.com

SIGNED: _____ DATE: _____
(Patient or Parent if under 18)

I hereby fully authorize Allergy and Asthma Comprehensive Care and/or their agent to bill, receive, release, and exchange information with my insurance carrier.

Patient or parent/legal guardian signature: _____Date:_____

Print patient or parent/legal guardian name: _____

Acknowledgement of Privacy Practice Notice:

I have received and/or been given the opportunity to have/read a copy of Allergy and Asthma Comprehensive Care's Notice of Privacy Practices. I also have access to the document for review at njallergycare.com. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Allergy and Asthma Comprehensive Care for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes.

_____ _____ _____
Signature of Patient or Legal Representative Print Legal Rep. Name (if applicable) Date

ALLERGY AND ASTHMA COMPREHENSIVE CARE

PATIENT: _____DOB:_____ DATE: _____

What is your MAIN reason for being here today? (Please circle ONE):

Asthma Food Allergy Environmental/Seasonal Allergies

Hives Eczema Sinus Issues Other_____

What are your other allergy concerns? (Circle all that apply):

Asthma Food Allergy Environmental/Seasonal Allergies

Hives Eczema Sinus Issues Other_____

Current Medication: Circle if NONE
(Please list all medications)

Medication *allergies*: Circle if NONE
(Please list medication allergies and reactions)

Do you have any chronic medical conditions? (Circle all that apply): NO

Cholesterol High blood pressure Thyroid condition Diabetes Heartburn/Reflux Cancer Other_____

Have you had any of these surgeries? (Circle all that apply): NO

Tonsils removed Ear tubes Adenoids removed Sinus Surgery Other_____

Do any immediate family members (parents,siblings,children) have these medical conditions? (Circle all that apply):

Allergies: Asthma Allergic Rhinitis Eczema Food allergy

Non-allergies: High blood pressure Cancer Diabetes Thyroid Other_____

Allergy/Social History:

Smokers in household? **Y/N** If yes, who? _____

Animals in home? (Please circle): None

Cats: How many? _____ Does it sleep in patient's bedroom? **Y/N**

Dogs: How many? _____ Does it sleep in patient's bedroom? **Y/N**

PATIENT: _____DOB:_____ DATE: _____

Primary flooring in home (please circle):

Carpet Non-carpet Non-carpet with area rugs

Flooring in patient's bedroom (please circle):

Carpet Non-carpet Non-carpet with area rugs

Bedding in patient's bedroom (please circle):

Feather/Down Pillow Allergy/Dust Mite covers on pillow

Feather/Down Comforter Allergy/Dust Mite covers on mattress

Does the house have a basement? (please circle): Y/N

If yes, is it finished? **Y/N**

If yes, is it dry? **Y/N**

Heating system in house (please circle):

Forced Air Radiant/Baseboard Woodstove/Fireplace

Cooling system in house (please circle):

Central Air Conditioner Window Air Conditioner None

Do you experience any of the following on a chronic/regular basis? (Circle all that apply): NO

Constitutional	Ears/Nose/Throat	Ears/Nose/Throat cont.	Musculoskeletal	Endocrine
Appetite changes	Hearing changes	Mouth breather	Arthalgia	Cold intolerance
Weight change	Tinntus	Sinus symptoms	Muscle pain	Heat intolerance
Fever	Taste change	Nasal congestion/obstruction	Muscle weakness	
Chills	Hoarseness	Post nasal drip	Stiffness	
Malaise	Thrush	Snores	Osteoporosis	
Fatigue	Nose bleeds			
Failure to thrive	Nasal discharge			

Cardiovascular	Gastrointestinal	Gastrointestinal (cont)	Neurological	Heme/Lymph
Chest pain	Indigestion	Abdominal pain	Epilepsy	Anemia
Edema (swelling)	Nausea	Heartburn	Stroke	Bruise easily
Fainting	Vomiting	Spitting up	Tingling	Bleeding
Palpitations	Diarrhea	Choking on food	Numbness	Swollen glands
Murmurs	Bloody stool		Speech delay	

Skin	Psychiatry	Respiratory (Non-exercise)	Respiratory (w/ exercise)	Eyes/Head
Itching	Anxiety	Shortness of breath	Cough	Vision changes
Rash	Depression	Cough	Wheeze	Shiners
Hives	Developmental delays	Sputum	Shortness of breath	Itchy, watery, red eyes
Angioedema	ADD/ADHD	Stridor	Chest tightness	Tension headache
Bruise easily	Irritable	Wheezing		Sinus headache
Skin frailty	Mood swings	Chest tightness		Migraine headache
Acne	Stress			Dizziness

Allergy & Asthma Comprehensive Care

Alex Marotta, M.D.

FINANCIAL AGREEMENT

Allergy & Asthma Comprehensive Care 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 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 the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

PAYMENT 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 your 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 FINANCIAL 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 that 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.

ALLERGY AND ASTHMA COMPREHENSIVE CARE NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Policy & Accountability Act of 1996 ("HIPAA") is a federal program **that** requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination or referral to a specialist.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. ***This includes the completion of physical exam forms for schools, and faxing immunization records to any other entity but you, unless the attached authorization form is completed and signed.*** You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a ***written request*** to Allergy and Asthma Comprehensive Care.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your protected health information. There is a fee involved with this service.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective January 1, 2009. From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. The revised notice will be posted at our place of service, and you may request a written copy from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with Allergy and Asthma Comprehensive Care. You may also file a complaint with the Department of Health & Human Services Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

ALLERGY AND ASTHMA COMPREHENSIVE CARE 541
Cedar Hill Avenue, Suite 8 Wyckoff, NJ 07481

(201) 652-6211

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights 200
Independence Avenue, S.W. Washington, D.C. 20201

(202) 619-0257 Toll Free: (877) 696-6775