ATUL N. SHAH, MD, FACAAI, FAAAAI
Janet E. Kelske, CPNP, ANP-C, AE-C
Desirie M. Zorn, PNP, AE-C

Dear Patient,

Welcome to our practice!

In order to facilitate your first visit to our office, attached is our "intake" paperwork so that you may review and complete prior to your visit. For your convenience you can either fax the completed paper work along with your ***insurance card*** *or you may bring it with you.*

If you have any blood work, hospital records or skin tests, please bring a copy of the results with you.

See the attached list of medications that must be stopped prior to your visit.

If your insurance plan requires you to have a referral to see a specialist, you must coordinate getting that referral from your primary care physician ***prior*** *to your appointment with us.* ***All copayments, by contract with the insurance companies, must be paid at the time of your visit.*** *We reserve the right to charge an additional service charge – currently $10.00 – for any copayment left unpaid on the date of service. For your convenience, we accept cash, check, credit/debit cards. It is your responsibility as the patient/insured, to be aware of the current terms of your insurance coverage****. Self-pay patients****- Payment is expected at the time of service.*

*We confirm all appointments, so we appreciate a call 24 hours prior to your exam if you will need to cancel or reschedule****. Any appointment not canceled within 24 hours will be subject to a $25.00 invoice mailed to your home.***

Divorced/Separated parents of minor patients- The parent who consents to the treatment of a minor child is responsible for the service charges related.

With your cooperation and assistance, you should be able to receive all the benefits offered to you and we will be able to concentrate on caring for medical needs.

I understand the office policy stated above and agree to accept responsibility as described above.

Patient Signature: _____ *Date:* _____
(If minor, parent signature)

Print Patient Name: _____

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Center4AsthmaAllergy.com

AmazingAllergist™

New York Food Allergy & Wellness CENTER

Patient Information

Patient's Last Name:_____ First Name:_____ MI:____ Date of Birth:_____

Patient SS# :_____ Sex:____M ____F Parent /Guardian(If Minor):_____

Address:_____City:_____State_____Zip_____

Home Phone:_____Cell Phone:_____Work Phone:_____

E-mail Address:_____Marital Status: ___S ___M ___D ___W

Primary/Referring Physician(s) Name:_____Address_____Phone #:_____

Pharmacy Name, Location and Phone #: _____

Occupation/Employer (Mother) _____ Occupation/Employer (Father) _____

Insurance Information – Primary Medical Insurance

Policy Holder's Name _____ DOB _____ SS# _____

Insurance Plan Name _____ Do you need a referral? _____ YES*(see note) ____ NO

Policy ID # _____ Group # _____ Effective Date _____ Copay _____

*As a patient/parent, you understand that if a referral is required, it is your responsibility to obtain a referral and provide our office with that document for the services provided by this practice. You are aware and understand that if a referral is noted obtained, you will be responsible for the charges of services rendered by our medical practice. ____ Initial of Parent/Patient (if minor)

Secondary Insurance? ___ Yes** ___ No **If yes, please indicate the following

Policy Holder's Name _____ DOB _____ SS# _____

Insurance Plan Name _____ Policy ID # _____ Group # _____

Assignment of Benefits and Release of Information

I authorize my insurance benefits to be paid directly to Atul N. Shah, MD, PC for all the medical services rendered. I understand that I am responsible for any account balance for medical services rendered that my insurance does not cover. I certify that the information I have reported with regard to my insurance is correct and accurate. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. I will notify you of any changes in the above information. I understand my rights under the HIPPA Privacy Laws and have been given the opportunity to ask questions about this notice and I can request a copy of the Notice of Privacy Practices.

Signature of Patient _____ Date _____
(Parent if minor)
Print Name _____ Relationship _____

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Patient Name:_____ Date:_____

Age:_____ Birth Date:_____ Sex: M / F Height:_____Weight:_____

Primary Care Provider:_____ Last Dose of Antihistamine: _____

Whom may we thank for referring you? _____

Chief Complaint(s):
Allergies / Asthma / Eczema / Food allergy / Drug Allergy / Cough / Hives / Other:_____

Eye Symptoms: Itchy eyes / watery eyes / red eyes / mucus in the eyes
Nasal: Runny nose / sneezing / itchy / nasal congestion / nose bleeds / snoring / thick-yellow-green mucus
Mouth: Bad smell / drainage down the throat
Asthma: Cough / wheezing / shortness of breath / tightness / chest pain
Sinus: Headache / sinus pressure / postnasal drip / bad smell / frequent sinus infections
Ears: Itchy ears / heavy / pain / frequent ear infections / hearing loss / ringing noise
Throat: Sore throat / frequent infections / swollen glands / drip
Skin: Rash /hives / eczema / itching / skin infections
GI Symptoms: Vomiting / diarrhea / pain / bloating

History of:
Asthma: Yes / No, If yes when were you diagnosed: _____
Insect Allergy:Yes / No, If yes what insect:_____
Food Allergy:Yes / No, If yes what foods:_____
-Document History: Food_____, First Reaction_____, Last Reaction_____,
Last Epinephrine_____, Last ER visit_____
Prior OIT – Y / N If Y, what food _____, Completed _____
List all food allergies: _____
Drug Allergy:Yes / No, If yes what drugs:_____
Latex Allergy: Yes / No
Emergency Rooms Visits:_____ Hospital Admissions: _____Reason:_____

Night time symptoms:
Day time symptoms:

These Symptoms Occur:
Spring / Summer / Fall / Winter
Few Days / Weeks / Months / All the time
At Home / At Work / Everywhere

Symptoms Get Worse :
Indoors / Outdoors / At Work / At School / At Home

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Symptoms are made WORSE by:
Common Cold (Infections) / Smoke / Heat / Mowing grass / Raking leaves /
Cold / Rain / Fog / Wind / Damp Areas / Food / Dusting / Cleaning /
Strong Odor / Perfumes / Cats / Dogs Other Triggers:

All Current Medications:

Name	Dose	Times per day
1		
2		
3		
4		
5		
6		

Last Menstrual Period:_____, Are you pregnant now: Yes / No , If yes, how far along:_____

Current Environment:
Home / Apartment / Condo
Years at present address:_____, How old is the building_____
Type of heating: __Radiator / __Baseboard / __Forced Hot Air / __ Wood burning stove
Type of Cooling: __Window Unit / __Central AC / __Fans / __None
Humidifier / Dehumidifier / Air Cleaner
Plants:_____
Recent Renovations / Construction
Basement: Damp / Not so damp
Visible allergens inside home:
__Mold Growth / __Roaches / __Rodents
Animals In Home
Cats:_____ / Dog:_____ / Birds:_____ / Other:_____
Type of Pillow: Foam / Feather / Down / Synthetic
Carpets: Wall to Wall / Area Rugs / None
Smoking:
____ Non Smoker
____Smoker for how many years? _____
____ Former Smoker. Quit smoking _____Months / Years ago
Is there any secondary smoke exposure? Yes / No

Family Members with:
Asthma:
Hay Fever:
Food Allergy:
Drug Allergy:
Eczema:
Hives:
Animal Allergy:
Sinus Problems:

History has been reviewed with patient:_____

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PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

Please review and agree that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for Knowing and Understanding their own Insurance Policy, Eligibility and Coverage.
- Patients are responsible for payment of outstanding Deductibles and Co-insurance. Co-payments will be collected at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Any appointment, including allergy testing, missed or not cancelled more than 24 hours in advance will incur a $25.00 charge.
- Returned checks are subject to a $35.00 fee.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.
- I understand that should it become necessary to take legal action to collect any outstanding balance after 180 days of non-payment, there will be an **additional 30% late fee** added to my delinquent balance.

The Patient or Patient's Legal Representative hereby acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician and Practices accordingly.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Guardian Date

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Center for Asthma & Allergy/ NY Food Allergy and Wellness Center's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting Center for Asthma & Allergy/ NY Food Allergy and Wellness Center's office manager.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This revised information supersedes any previous version of our privacy practices notifications. Any previous written instructions submitted under our previous policy need to be resubmitted in writing under this revision.

I hereby authorize the following individuals to interact with employees of Center for Asthma & Allergy/ NY Food Allergy and Wellness Center, to receive and provide Protected Health Information regarding me. This listing shall remain in effect until revoked in writing by me. (Please check more than one if needed.)

____ Myself only

____ My Spouse _____

____ My Adult Child(ren) _____

____ The Following Friends and/or Family:_____

For minor children: I am the custodial parent/guardian of _____ and I may legally receive this information.

I have read and reviewed Center for Asthma & Allergy/ NY Food Allergy and Wellness Center's Notice of Privacy Practices.

PATIENT NAME_____DATE OF BIRTH_____

SIGNATURE_____DATE_____

RELATIONSHIP TO PATIENT_____NAME(GUARDIAN)_____

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Please be aware if you are on any of the following medications.
You MUST be off them **3 days** prior to any allergy testing.

Prescription Antihistamines	Non-Prescription Anithistamines
-AlleRx -Doxepin -Hydroxyzine (Atarax) -Meclizine -Naldecon -Periactin -Phenergan -Rynatan -Tussionex -Tussi-12 -Vistaril -Dymista Nose Spray -Astepro/Astelin Nose Spray -Patanase Nose Spray ***If you are not sure, please call our office to confirm**	-Actified -Advil Allergy sinus/ Advil PM -Alka-Selzer Plus Sinus Allergy -Allerest -A.R.M -BC Cold Pwder Multi Symptom -Benadryl -Cetirizine (Zyrtec, Zyrtec D, and other brands) -Chlor-Trimeton (Chlorpheniramine) -Comtrex Multi-Symptom -Coricedin -Dimetane -Dimetapp -Drixoral -Fexofenadine (Allegra, Allegra D, and other brands) -Loratidine (Claritin, Claritin D) -Motrin Allergy sinus/ Motrin PM -Pedicare Night Rest -Percogesic -Robitussin Night Time Cold -Sinarest -Sudafed Plus -Tavist -Triaminic Allergy -Tylenol Allergy Sinus/ Tylenol PM/ Flu PM If any OTC meds are for cold & sinus/ sleep aids or influenza please also avoid.

The following Medications you must be off for **7 days** prior to any allergy testing

-Levocetirizine (Xyzal)	-Dexamethasone
-Desloratadine (Clarinex)	-Decadron Elixir
-Prednisone	-Orapred
-Medrol Dose Pack	-Prednisolone

****All topical creams are OK****

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