Asthma, Allergy & Sinus Center
3600 Leonardtown Road, Suite 103, Waldorf, MD 20601
Office: 301-843-2223  Fax: 301-705-9720

Use and Disclosure of Protected Health Information
PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

The educational pamphlet “Notice of Privacy Practices” provides information about how Asthma, Allergy and Sinus Center may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

______________________________________________________________
Patient/Guarantor Signature                                      Date

Consent for Use and Disclosure of Information

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

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Asthma, Allergy and Sinus Center for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

______________________________________________________________
Patient/Guarantor Signature                                      Date

Print Full Name

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPPA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services.
Financial and Appointment Policies

In order for us to provide the best service to our patients, we are providing the following updated policies. Please read, sign, date and return to the front desk.

Financial Policy
I acknowledge that I am responsible for my copayment at the time of service. I am responsible for any deductibles or non-covered services and any outstanding balance on my account to be paid within thirty (30) days upon receipt of our statement.

Referrals
If I do not provide a required referral for my office visit, my appointment will be rescheduled. The office staff will not call my primary care physician to obtain a referral because it is my responsibility.

Cancellation Policy
Effective January 1, 2017, 24-hour notification is required should I need to cancel or reschedule my appointment. Failure to show without 24-hour notification will generate a $25.00 “No Show” fee which will be my responsibility. This is not covered by my insurance and I will be fully responsible for this charge.

Medical Records Fee
In accordance with Maryland Law, there is a charge for copying medical records. This charge is $22.88 but we are reducing this charge for our patients to only a $10.00 preparation fee. The price per copied page is of $0.50 for the first fifty (50) pages, and $0.25 thereafter. The cost of mailing medical records is the actual postage value.

Completion of Disability, FMLA Forms and Letter Fees
There is a $25.00 charge per form for the completion of all disability and FMLA forms. Please allow up to two (2) weeks for the form(s) to be completed. There is also a $25.00 charge for all letters drafted by our office at your request. Cost of extensive letters will be $50.00 for the first page and $25.00 for each additional page. Payment must be made in full prior to releasing the letter.

I have read the above policies, understand, and agree to comply.

_________________________________________  ____________________________
Patient/Guardian Signature                        Date
Patient's Authorization

I authorize ASTHMA ALLERGY + SINUS CENTER to apply for benefits on my behalf for services rendered by ASTHMA ALLERGY + SINUS CENTER. I request payment from my insurance company be made directly to ASTHMA ALLERGY + SINUS CENTER. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Signature of Subscriber or Beneficiary

Date
New Patient Visit

Name: ____________________________  Age: ____________

Sex (circle)  M  F  Reason for Visit

1. ____________________________
2. ____________________________
3. ____________________________

Primary Care Physician: ____________________________
Primary Care Address: ____________________________
Primary Care Phone: ____________________________

Occupation (current/former):

COMPLAINTS (check all that apply)

<table>
<thead>
<tr>
<th>Rash</th>
<th>Mouth breathing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hives</td>
<td>Nasal congestion</td>
</tr>
<tr>
<td>Eczema</td>
<td>Runny nose</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Post nasal drip/drainage</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Sinus headaches/infections</td>
</tr>
<tr>
<td>Snoring</td>
<td>Itchy, watery, red eyes</td>
</tr>
<tr>
<td>Sneezing</td>
<td>Bee sting reaction(s)</td>
</tr>
<tr>
<td>Coughing</td>
<td>Food reaction(s)</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Medication reaction(s)</td>
</tr>
</tbody>
</table>

These symptoms occur (circle all that apply):
Spring  Summer  Fall  Winter  Indoors  Outdoors  Morning  Night

When did symptoms start? ____________________________

IF YOU HAVE FREQUENT INFECTIONS:

# of ear infections in past year: ____________
# of sinus infections in past year: ____________
Last sinus CT scan Date (if any): ____________
# of pneumonia infections in lifetime: ____________
Last Chest X-Ray Date (if any): ____________
# of courses of Antibiotics in the past year: ____________

IF YOU HAVE ASTHMA:

Diagnosis of asthma made ____________ yrs ago (or at age: ____________)
# of hospitalizations for asthma: ____________ Dates(s): ____________
# of ER visits for asthma per year: ____________ Last ER visit ____________
# of missed work/school days in past year: ____________
# courses of Prednisone for asthma: ____________ Last course: ____________
Do you have a spacer for your inhaler? ____________ Do you use it? ____________

IF YOU HAVE ENVIRONMENTAL ALLERGIES:

Have you had any previous allergy testing? Yes  No
__________ skin testing  _______ allergy blood tests

What were you allergic to?
Animals  Dust/mites  Pollen  Mold  Feathers

Previous Allergist: ____________________________
Previous allergy shots? Yes  No  Age: ____________
Still on allergy shots? Yes  No
Shots received every ____________ week(s) for ____________ mos/ysr
Were the shots helpful? Yes  No
Did you have any reaction other than minor local? Yes  No

Do chemicals or smoke bother you significantly? ____________

IF YOU HAVE FOOD/MEDICATION/BEE ALLERGY:

<table>
<thead>
<tr>
<th>FOOD/MED/BEER</th>
<th>DATE/AGE</th>
<th>WHAT WAS THE REACTION?</th>
</tr>
</thead>
</table>

LIST ALL MEDICATIONS – PRESCRIPTION OR OVER THE COUNTER

Use additional sheet if necessary  □ Check if list is attached

<table>
<thead>
<tr>
<th>Medication</th>
<th>Helpful?</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inhalers</th>
<th>Y</th>
<th>N</th>
<th>Dosage</th>
<th>Puffs</th>
<th># Times a day</th>
</tr>
</thead>
</table>
### Past Medical History/Chronic Health Conditions
- High Blood Pressure
- Diabetes
- Cataracts
- Sleep Apnea
- Acid reflux
- Glaucoma
- Thyroid Disorder
- HIV
- Other: ____________________________

#### Hospitalizations
<table>
<thead>
<tr>
<th>Year or Age</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### Surgeries
<table>
<thead>
<tr>
<th>Year or Age</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Review of Systems: Do you have ANY of the following symptoms?

**General:**
- Weight change
- Appetite change
- Activity change
- Fatigue
- Dizzy
- Feeling hot/cold

**Eye/Nose/Throat:**
- Sore Throat
- Voice change
- Decreased sense of smell
- Swollen glands
- Mouth ulcers
- Nose bleeds
- Blurred vision

**Neurologic:**
- Change in sensation
- Depression
- Sleep problems
- Constant thirst

**Gastrointestinal/Genitourinary:**
- Nausea
- Constipation
- Change in periods
- Frequent urination
- Bladder infections

**Hematologic:**
- Easy bruising

### Family History (parents, grandparents, siblings, children, aunts or uncles only)

<table>
<thead>
<tr>
<th>Illness (circle)</th>
<th>Family Relation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seasonal Allergies/Hayfever</td>
<td>Food allergy</td>
</tr>
<tr>
<td>Medication allergy</td>
<td>Asthma</td>
</tr>
<tr>
<td>Recurrent infections</td>
<td>Eczema</td>
</tr>
<tr>
<td>Hives</td>
<td>Swelling/angioedema</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Childhood diabetes</td>
</tr>
</tbody>
</table>

### Social History

**Marital Status:**
- Single
- Married
- Divorced
- Widowed

Who do you live with? ____________________________

Do you smoke? Yes No Quit ___ yrs ago

How long have you/did you smoke for? ___ yrs

How many packs per day? ___

How often do you drink alcohol? Never Other: ____________________________

Have you ever been treated for alcohol/drug abuse? Yes No

### Environmental History

Describe your home: House / Apartment / Townhouse / Trailer / Basement

How long have you lived there? ___ years  Age of home ___ years

Type of heating: Forced air / space heater / electric / hot water / wood stove

Type of cooling: Central / Window units / Windows / Fans

**Bedroom:**
- Flooring: Wall to wall carpet Hardwood Area rugs
- Pillow: Synthetic Down/Feather Allergy cover
- Bedding: Synthetic Down/Feather Mattress Allergy cover
- Stuffed animals: Yes No

**Living Room(s):**
- Wall to wall carpet Hardwood Area rugs

**Window treatments:**
- Blinds Curtains Shades

Do you have: House plants Roaches Humidifier Smokers in home

Mold/mildew problems (if yes, describe: ____________________________)

Do you have pets? Yes No

If yes, list each type and how many: ____________________________

Do they ever come into the house? Yes No

### Physician’s Notes Only:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________