Asthma, Allergy, & Sinus Center

Sudhir Sekhsaria, MD • Manav Singla, MD • Gitika Dhillon, MD • Amber Viel, FNP-C

Dear Patient,

Thank you for scheduling an appointment with our office. To better serve you, we ask that you please bring the following information with you to your appointment:

1. Insurance card(s)
2. Referral (if applicable)
3. Co-payment (if applicable). We accept cash, check, Visa, MasterCard and Discover
4. Picture ID
5. Completed new patient registration form
6. Completed new patient intake form
7. Signed Privacy Act (HIPPA)
8. All medications and inhalers including spray devices and spacer chambers.

We ask that you wear a <u>short sleeved shirt</u> and <u>STOP</u> taking the following medications 5 days prior to your first appointment:

- **<u>Prescription antihistamines</u>** such as desloratine (Clarinex), levocetirizine (Xyzal), hydroxyzine (Atarax) or cyproheptadine (Periactin).
- **<u>Over-the-counter antihistamines</u>** such as Benadryl (dipenhydramine), Claritin (loratadine), Alavert (loratadine), Chlor-Trimeton (chlorphenamine), Zyrtec (cetirizine), Allegra (fexofenadine), Nyquil, or any other over the counter medicine that contains an "antihistamine" in the active ingredients.
- **<u>Nasal antihistamine spray</u>** azelastine (Astelin), Patanase, Astepro, Dymista
- **<u>Tricyclic Antidepressants</u>** such as doxepin (Sinequan), amitriptyline (Elavil), nortriptyline (Pamelor), imipramine (Tofranil)
- Stop Singulair 1 day prior to your appointment.

- **<u>CONTINUE all asthma inhalers</u>** as prescribed. We ask that you skip your morning inhaler dose the morning of your appointment if possible.

Before your appointment we advise you to verify your insurance benefits for allergy services. If your benefits do not cover allergy services, you will be notified of our Self Pay Fees. Self Pay Fees are due at the time of service.

If you have your doctor fax a referral or any other medical records to our office, please call the office prior to your appointment to assure that we have received the information. If your insurance company requires you to have a referral for specialty services, please make sure that you obtain one from your primary care physician. You will not be seen without a valid referral. We cannot call your primary care physician for your referral. **<u>It is your responsibility to bring your referral to each appointment.</u>** All referrals will expire and are only valid for a certain number of visits. Please keep track of your referrals for future visits.

For your convenience, you will find directions to our office on the reverse side of the paper. If you have any questions, please call our office.

Your appointment date is: ___________________________________ Time:___________

You will be seeing: ____

Please call 48 hours in advance if you cannot make your appointment for the consideration of the office and other patients. A $25.00 no show fee may be billed for missed appointments.

Office Policy

If your insurance company requires you to have a valid referral each time you see a specialist physician:

- It is your responsibility to bring your referral to each appointment.
- It is your responsibility to keep track of your referral's expiration date and number of visits allowed. If your referral has expired or has no visits left, you must call your primary care physician to request a new referral.
- You may ask your physician to fax your referral to (410) 933-9405. However, please call our office prior to your appointment to assure we have received it.
- **If you do not have a valid referral, you will have to reschedule your appointment.** No exceptions will be made.

Please call 48 hours in advance if you cannot make your appointment for the consideration of the office and other patients. A $25.00 no show fee may be billed for missed appointments.

Copay Policy

If your insurance company requires you to pay an office visit/specialist co-pay, **you are required to pay your co-pay at the time that services are rendered to you**. Please have your co-pay ready to give to the secretary at the front desk.
We accept cash, check, debit, Visa, Mastercard, and Discover.

Physician Follow-Up Visits

If you remain under the physicians care, you must have a follow-up appointment every 6 months. If you have not followed up with the physician, your medications will not be refilled.
Please request all refills at your follow-up appointment.

Patient Statements

If you receive a billing statement from our office and you do not agree with the processing of your claim, please contact your insurance carrier first so that they can explain how your claim was processed. Please get the name of the representative your spoke to and feel free to call our billing department (410-933-9404), Monday-Friday 10am-5pm if you have any further questions.

Thank you.

Asthma, Allergy & Sinus Center staff

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Patient Name: (*Last*) ________________________ (*First*)________________________ (*M.I.*)____

Date of Birth ____/____/______ Sex M F Age _____ Patient SS# _____-_____-________

Address ____

City ____ State ______ Zip _______________

Home Phone # _______________________________ Cell Phone # ___________________________

Email ____

Occupation _____________________Employer ____

Employer Address ___________________________________Work Phone # ___________________

Primary Care Provider _______________________________________ Phone # _______________

Physician's Address ____

Referring Physicians Name, Address and Phone # *(if different than Primary Care Provider)*

____

Responsible Party (*required if minor*) ____________________ Relationship to patient ________

Address ____

City ____ State ______ Zip _______________

Cell Phone # ___________________ Work # ___________________ Home #_______________

Date of Birth _______/_______/___________ SS# ________-________-________

Primary Insurance _______________________________________ Effective Date __________

Policy Holder's Name ____________________________________ Relationship to PT ______

Policy Holder's Address _________________________________ Phone # _________________

Policy # _______________________________________ Group # _________________________

Billing Address ____

Date of Birth _____/_____/______ SS# ______-______-______ Employer __________________

White Marsh 410-933-9404 Union Memorial 410-554-6516 Bel Air 410-933-9405

Asthma, Allergy, & Sinus Center

Sudhir Sekhsaria, MD ● Manav Singla, MD ● Gitika Dhillon, MD ● Amber Viel, FNP-C

Do you have a Specialist Copay? YES or NO. If yes, how much $ ______________________
Does your insurance require a referral to see a Specialist? YES or NO
It is your responsibility to inquire and bring your referral to each appointment.

Secondary Insurance __________________________________ Effective Date __________

Policy Holder's Name __________________________________ Relationship to PT ______

Policy Holder's Address ________________________________ Phone # ________________

Policy # _____________________________________ Group # ________________________

Billing Address ____

Date of Birth _____/_____/______ SS# ______-______-______ Employer _________________

Do you have a Specialist Copay? YES or NO. If yes, how much $ ______________________
Does your insurance require a referral to see a Specialist? YES or NO
It is your responsibility to inquire and bring your referral to each appointment.

Emergency Contact ______________________________________ Phone # ________________

Relationship to Patient ____

Your Pharmacy Name _____________________________________ Phone # _______________

How did you learn of our practice? ____

Patient Authorization and Consent

I authorize the release of any information relating to all claims and benefits submitted on behalf of myself and or/dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claims to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I also authorize insurance payment be made directly to the physician. I give consent for evaluation, including allergy testing and medical treatments including allergy shots if indicated for me or my dependent. I understand shall there be a problem or denial from my insurance company that I remain responsible for all services rendered.

Signature ____ Date __________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEED 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 your 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 Disclosers 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 with a third party. For example, we may disclose your PHI 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 Operation: We may use or disclose, as needed your PHI 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 arrange for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will b asked to sign your name and indicate your medical provider. We may also call you by name in the waiting room when your medical provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI 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: Food and Drug Administration requires: 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, except to the extent that your physician or the phycian's practice has taken an action in reliance on the use to disclosure indicated in the authorization.

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 proceedings, 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 party of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 in writing 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI 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 use or 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 HIPPA 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: _________

Asthma, Allergy & Sinus Center
Adults and Pediatrics

NEW PATIENT INTAKE FORM

Please check the correct box and/or write answers next to the question

Name: ______________________ Birthdate: ____________ Today's Date: ____________

Please describe in a few words why you are here:

____

____

____

What kind of work do you do? If child, what grade? ______________________

MEDICATIONS

What medications do you take on a daily or frequent basis, prescription and non-prescription, with doses if known. Include all pills, sprays, inhalers and supplements: *(there is additional room at the end if needed)*

____

____

____

____

ALLERGIES

List any medications you are allergic to, the nature of the reaction, and how long ago:

____

____

____

ENVIRONMENTAL HISTORY

	YES	NO
Do you live in a: ❑ single-family house ❑ townhouse ❑ apartment		
Do you have carpet in the bedrooms?	❑	❑
Do you have carpet in most of the house?	❑	❑
Do you have central air conditioning?	❑	❑
IF you have a basement, has there ever been any mold damage?	❑	❑
Do you have or are you around pets?	❑	❑
LIST all pets (indoor & outdoor) or animals you are frequently around: ______________________		
Does anyone who lives in the home smoke?	❑	❑
If patient is a young child, are they at home during the day, in school, or with another caretaker? ______________________		

ALLERGY HISTORY

	YES	NO
Have you ever been diagnosed with asthma, allergic rhinitis (hay fever, "allergies") or eczema?	❑	❑
When you were a young child, did you have allergies, asthma or eczema?	❑	❑
Have you ever been allergy skin tested? If so, when, and what were you allergic to? ______________________	❑	❑
Have you ever been on allergy immunotherapy / shots?	❑	❑
Have you ever had a reaction to FOOD? LATEX? INSECT STINGS?	❑	❑
IF you do have allergies, what medications have you tried, and did they help? Please list: ______________________		

FAMILY HISTORY

	YES	NO
Does anyone in your close and distant family have asthma, allergies, eczema or recurrent sinus problems?	❑	❑
If YES, please write who and what ______________________		

What other chronic illnesses run in your family:

❑ diabetes ❑ high blood pressure ❑ heart attacks ❑ heart disease ❑ cancer
❑ recurrent infections ❑ rheumatoid arthritis ❑ lupus, osteoporosis ❑ immune problems ❑ cystic fibrosis
❑ other: ______________________

Asthma, Allergy & Sinus Center
Adults and Pediatrics

PAST MEDICAL HISTORY	**YES**	**NO**
What medical problems do you have? ______________________________		
Have you ever had surgery? If YES, what and approximately when? ______________________________	❑	❑
Have you ever been in the hospital overnight for reasons other than surgery?	❑	❑
If YES, please list: ______________________________		
Have you ever had to visit the emergency room for any reason other than those listed above?	❑	❑
If YES, please list: ______________________________		
Have you ever been to the emergency room for asthma?	❑	❑
If YES, how many times and when? ______________________________		
Have you ever been hospitalized overnight for asthma?	❑	❑
If YES, have you ever been in the intensive care unit?	❑	❑
If patient is a child, was the child born premature?	❑	❑
Have you ever been a smoker?	❑	❑
If YES, how many years (approximately)? How many packs per day (2, 1, ½, less than ½)?	❑	❑
If you have quit, when? ______________________________		

REVIEW OF SYSTEMS - Please check problems you have had recently.

General:	❑ Fevers	❑ Chills	❑ Weight Loss (unintended)	❑ Night Sweats	❑ Loss of Appetite
Eyes:	❑ Itch	❑ Pain	❑ Excessive Tears	❑ Dry	❑ Loss of Vision
Ears / Nose / Throat:		❑ Congestion	❑ Runny Nose	❑ Nosebleed	❑ Sore Throat ❑ Ear Pain
		❑ Hoarse Voice	❑ Sinus Problems	❑ Loss of Hearing	❑ Ringing in Ears
Heart:	❑ Chest Pain	❑ Palpitations / Rapid or Irregular Heartbeat		❑ Swelling of Ankles	
Respiratory:	❑ Cough	❑ Wheeze	❑ Shortness of Breath	❑ Coughing up Blood	❑ Coughing up Phlegm
GI:	❑ Nausea	❑ Vomiting	❑ Heartburn	❑ Indigestion	❑ Bitter / Acid Taste in Mouth
	❑ Diarrhea	❑ Abdominal Pain	❑ Constipation	❑ Blood in Stools	
GU:	❑ Difficulty Urinating				
MSK:	❑ Joint Pain	❑ Joint Swelling	❑ Muscle Pain		
Skin:	❑ Rash	❑ Itch	❑ Hives / Welts	❑ Swelling	❑ Dryness
Neuro:	❑ Headaches	❑ Weakness	❑ Seizures		
Psych:	❑ Anxiety	❑ Depression	❑ Sleeping Poorly		
Immune:	❑ Frequent / Persistent Infections		❑ Pneumonia greater than 2 times		
GYN:	❑ Currently Pregnant or Planned in the Near Future				

WHAT SPECIFIC QUESTIONS DO YOU HAVE FOR THE DOCTOR?

Please feel free to write them down here.

____

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____

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Signature: ______________________________