Registration :

Asthma & Allergy Medical Care

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate Age	Social Security #

Address	Home: Work: Cell:	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician

Physician	Family Physician	Referring Physician

Medical Insurance

Medical Insurance Name & Address	Policyholder	Relationship	Policy ID	Group ID
1				
2				
3				

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Asthma & Allergy Medical Care , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Asthma & Allergy Medical Care
68 Nassau Road
Huntington, NY 11743
Phone: 631-423-5590
Email:

Please attach all pertinent insurance ID cards for photocopying.

Registro : **Asthma & Allergy Medical Care**

Fecha	No. De Cuenta	No De Expendiente	Orto ID	Uso Interno

Informacion Sobre El Paciente

Apellido	Primer Nombre	Inicial	Género	Estado Civil	Fecha de Nacimiento Age	Uso Interno

Direccion 1	Telefo	How did you hear of us?
	Telefon	
Dereccion 2	Telefo	
	Direcci	

Ciudad	Estado	Codigo Postal	Empleador	Occupación

Persona de Notifical	Phone	Farmacia	Telefono

Médico	Family Physician	Referido

Compania de Seguro	Numbre Y Direcci	Numbre de Persona Respons	Relacion	No. de Suscripton	No de. Gru
1					
2					
3					

Personal Responsible O Nombre de Otras Persona Responsable de Estacuenta

1 Apellido	Primer Nombre	Inicial	Género	Estado Civil	Fecha de Nacimiento	Uso Interno

Direccion 1	Telefono Personal	Telefono de	Direccion de Email

Ciudad	Estado	Codigo P	Empleador	Occupación

2. Apellido	Primer Nombre	Inicial	Género	Estado Civil	Fecha de Nacimiento	Uso Interno

Direccion 1	Telefono Personal	Telefono de	Direccion de Email

Ciudad	Estado	Codigo P	Empleador	Occupación

HIPAA Approved Contacts

1. Apellido	Primer Nombre	Inicial	Género	Fecha de Nacimi	Uso Interno	Relacion

Direccion 1	Ciudad	Estad	Codigo Post	Telefono Personal	Telefono de Celu	Telefono de Empleado

2. Apellido	Primer Nombre	Inicial	Género	Fecha de Nacim	Uso Interno	Relacion

Direccion 1	Ciudad	Estado	Codigo Post	Telefono Personal	Telefono de Celu	Telefono de Empleado

Trapasu de Lus Benefiaius Dec Seguro y Authorizacion Para la Divalgacion de Informacion

I the undersigned give my authorization to treat and assign directly to Asthma & Allergy Medical Care , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Firma	Fecha de Firma
X	

Asthma & Allergy Medical Care
68 Nassau Road
Huntington, NY 11743
Phone: 631-423-5590
Email:

Please attach all pertinent insurance ID cards for photocopying.

ACKNOWLEDGEMENT

I,______________________________, acknowledge that I have received a copy of Asthma & Allergy Medical Care, PC Notice Regarding Privacy of Personal Health Information.

Date:____________________

____
Signature
(Patient, Parent, Guardian)

ASTHMA & ALLERGY MEDICAL CARE, PC
FINANCIAL AGREEMENT

We appreciate the confidence that you have expressed in selecting us as your physicians. If you have any questions regarding our services, fees or other aspects of your care, please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:

- Patients without insurance
- Patients with private insurance
- Patients who are not covered by one of our contracted insurance plans. (PPO, HMO, EPO, POS, MC)
- Patients who do not provide us with contracted insurance information

For Medicare and contracted insurances, we will bill all services at no charge as per the requirements of the insurance contract.

All monies owed by the patient (co-pays, deductibles and non-covered services) are payable at the time of the service. For patients with contracted insurance policies, all co-pays and deductibles are to paid each and every visit. Patients with private insurance or no insurance are required to pay on their account each and every visit.

Any patient that is seen or treated in our office, without prior authorization from their contracted group, is responsible for the full charge of the visit.

Patients will be responsible for obtaining appropriate physician referrals before their scheduled office visit, otherwise, payment in full will be required at the time of the service.

If you need to use a specific lab or x-ray facility, you must notify the nurse before the service is rendered.

Any service that is rendered by this office, that is not a covered benefit of your insurance policy, is your responsibility to pay.

It is your responsibility to inform the office staff of any changes with your insurance coverage.

Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy.

It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

I have read and understood the above information.

______________________________ ______________

Signature (Patient/Parent/Guardian) Date

Asthma & Allergy Medical Care, PC

CONSENT TO RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)

Immunotherapy (allergy shots) is a treatment used to relieve allergy symptoms of hay fever or allergic asthma by administering injections of substances such as pollens, mold spores, house dust mites, or animal danders to which an individual has been found to be allergic by skin testing or a positive blood test (RAST). Allergy injections have been shown to lead to the formation of blocking or protective antibodies. These changes may permit you to tolerate exposure to the allergens with fewer symptoms. The amount of this immunization occurs to a different extent for each person.

Allergy shots are administered only to allergic patients who have severe symptoms not controlled by environmental control measures or medications, or which persist and require daily medications.

Improvement should not be expected immediately. It usually requires 4-6 months before any relief of allergy symptoms is noticed and it may take 12 months for the full benefits to occur. About 80% of allergic individuals on immunotherapy get significant improvement of their symptoms.

Allergy injections are usually begun at a very low dose. This dose is gradually increased on a weekly basis until a "maintenance dose" is reached. This frequency reduces the chances of a reaction. The goal is to eventually spread the shots to every 4 weeks for a period of 3-5 years. It is important that the recommended schedule be followed. Allergy injections may be discontinued if visits are frequently missed because there is an increased risk of reactions under those circumstances.

Local reactions (swelling, itching or tenderness at the site of the injection) may occur in most patients receiving injections. These local reactions usually subside in a day or less. Large local and generalized (systemic) reactions may occur in a small percentage of patients receiving allergy injections and usually occur during the build up phase, although they may occur at any time during the course of treatment. These reactions may consist of any or all of the following symptoms: itchy eyes, nose or throat, runny nose, nasal congestion, sneezing, tightness in the throat or chest, coughing wheezing. Also, some may experience lightheadedness, faintness, nausea and vomiting, hives, and, under extreme conditions, shock.

It is the responsibility of each patient to:

1. remain in the office under observation for at least 20-30 minutes following their allergy injections.
2. notify the medical staff of *Asthma & Allergy Medical Care, PC* **prior** to receiving any injection(s) if you are experiencing fever, chest tightness, wheezing, shortness of breath, or chest pain.
3. notify the medical staff if you are taking any beta-blocker medication for treatment of any medical condition.

Asthma & Allergy Medical Care, PC

CONSENT TO RECEIVE IMMUNOTHERAPY (ALLERGY SHOTS)

I have read the patient information letter regarding immunotherapy (allergy shots) on the preceding page. Professional supervision will be present during the administration of my treatment and the observation thereafter for appropriate precautionary measures as well as treatment should it become necessary.

In the event of an adverse reaction, I authorize and accept responsibility for appropriate treatment as directed by *Asthma & Allergy Medical Care, PC.*

I understand that as of this date the available information indicates that treatment must continue for a period of 3-5 years to be maximally effective.

I have read this document and understand its contents. I have been given the opportunity to ask questions.

With knowledge of the above information, I hereby choose the begin treatment for my condition.

______________________________ _______________

patient's signature date