



D. Loren Southern, M.D. Andrew J. Pedinoff, M.D. Julie A. Caucino, D.O.
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Jayanti J. Rao, M.D. Shaili N. Shah, M.D.

Princeton 609-921-2202 Plainsboro 609-799-8111 Hamilton 609-888-1555
Flemington 908-782-0093 Kendall Park 732-821-0595
Fax #: 609-924-1468

What to bring to first appointment

- **You must have with you any related allergy testing, lab results, CT Scan or X-ray results, biopsy results, list of current medications, including “over the counter”, dosage and time of day you take it and any other medical records necessary for the doctor to properly assess and treat the patient.**
- **If appointment is for food allergy, bring food log with ingredient information and corresponding symptoms.**
- Insurance Card and Copay
- If a referral is required, please contact your Primary Care Physician. Some insurances prohibit us from seeing the patient without a referral.
- Photo ID of Patient (if patient is under 18, bring parent photo ID)
- Completed New Patient forms from “forms” section of the website
- If appointment is for rash (dermatitis) or hives, please complete Screening for Rashes form from “forms” section of the website

Princeton Allergy & Asthma Associates, P.A.

PATIENT INFORMATION

(Please use BLACK PEN Only)

Name _____ Sex M F Date of Birth ___/___/___
Street Address _____ City _____ State _____ Zip _____
Primary Phone (_____) _____ Home ___ Cell ___ Ok to leave extended message? Yes No
(cell # must be parent's if patient is under 18)
Secondary Phone (_____) _____ Home ___ Cell ___ Ok to leave extended message? Yes No
Work Phone (_____) _____ Ext _____ Ok to leave brief message? Yes No Extended message? Yes No
(Princeton Allergy & Asthma Associates, P.A. will leave a brief message on any home or cell phone number listed)

Marital Status? Single Married Divorced Widow SS # _____ Email Address _____

Race _____ Ethnicity Hispanic Not Hispanic N/A Preferred Language _____

Referring Physician _____ Address _____ Phone (____) _____

Primary Care Physician _____ Address _____ Phone (____) _____

Emergency Contact we may release medical information to _____ Relationship _____ Phone (____) _____

How did you hear about us? Doctor Friend Insurance Company Internet Search Yellow Pages Family Previous Patient

RESPONSIBLE PARTY INFORMATION (for children under 18, parent must be present for appointment)

Name _____ Date of Birth ___/___/___ SS# _____ Sex M F

Street Address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext _____

Relationship Parent Legal Guardian Other _____ Marital Status? Single Married Divorced Widow

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group # _____ Effective Date ___/___/___

Subscriber _____ Date of Birth ___/___/___ Sex M F Relationship to insured Self Spouse Child Other _____

Street Address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext _____

Secondary Insurance _____ ID# _____ Group # _____ Effective Date ___/___/___

Subscriber _____ Date of Birth ___/___/___ Sex M F Relationship to insured Self Spouse Child Other _____

Street Address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____ Ext _____

Any Other Insurance Yes No If Yes, Please list _____

I have been offered a copy of Princeton Allergy & Asthma Associates P.A. Notice Regarding Privacy of Personal Health Information. I authorize the release of any medical or other information necessary in the processing of my claims. I also request the release of payment be made directly to Princeton Allergy & Asthma Associates, P.A.

Signature _____ Date ___/___/___

CLINICAL RESEARCH

PAAA physicians are involved in clinical research. PAAA may provide you with information regarding clinical studies that you may want to participate in. Most of the clinical research studies are conducted by PAAA's affiliate organization, Princeton Center for Clinical Research. Any use or disclosure of your medical information for research purposes will maintain the privacy of your medical information and you will not be personally identified.

Would you like information on the benefits of participation in Clinical Research? Yes No (If YES, please read the following statement and sign below)

I authorize the release of my medical information to Princeton Center for Clinical Research. I understand that this authorization has no expiration and I may revoke this authorization at any time, giving written notice to the health care provider.

Signature _____ Date ___/___/___

6/01/17



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Payment Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance.** We participate in most insurance plans, including Medicare. If you are insured by a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you have regarding your coverage.
- 2. Responsibility for Medical Care.** Every minor child, under the age of 18, seen in our office for medical services must be accompanied by a parent or legal guardian, or by an adult who has obtained written consent for treatment from the parent or legal guardian. The accompanying parent of a minor will be responsible for copayments, co-insurance, deductibles, & non-covered services. In the case (such as divorce) it will be up to him/her to seek repayment from the other parent. Our top priority is to treat your child’s medical needs, not be placed in the middle of your dispute.
- 3. Copayments.** All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.
- 4. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at time of service or with-in **14** days of billing statement.
- 5. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 6. Claim submission.** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If they have not paid within **60** days, the balance will be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 7. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
- 8. Nonpayment.** If your account is over **30** days past due, you will receive a letter stating that you have **14** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid past **45** days, we may charge a service fee of \$30 and refer your account to IC SYSTEM, a National Collection Agency authorized to credit report all debts to the four major National Credit Agencies and litigate in a court of law. Where any part of your medical account with PAAA has fallen into arrears, then the totality of that account shall become immediately due and payable.
- 9. Additional cost of collection services.** Invoices shall be deemed to be accepted by you unless PAAA is notified in writing within **14** days of the invoice that you dispute it. In the event of delinquent accounts, PAAA will charge a service fee. In addition, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys’ fees, we incur in such collection efforts.

Payment Policy is subject to change without notice.

I have read and understand the payment policy and agree to abide by its guidelines.

Print Patient Name _____

Signature of patient or responsible party _____ **Date** _____

6/13/18

Please sign both sides. Over →



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Office Policy

Patients with HMO or POS Plans:

- A valid referral must be presented at the time of your appointment; patients are responsible for payment in full if the proper paperwork is not on file.
- Our office must have a valid referral on file prior to preparing allergy serum for patients.
- It is the patient’s responsibility to keep track of authorized visits to our office.

All Patients

- Patients receiving allergy injections **must** wait 30 minutes before leaving our facility.
- All patients under 18 years of age must be accompanied by their parent or guardian.

Prescription refills

- **BEFORE CALLING OUR OFFICE FOR A REFILL, PLEASE CHECK YOU’RE YOUR PHARMACY if any refills are present.** If no refills are present please have your pharmacy contact us. We do require 72 hours notice if a prescription is needed.
- For proper medical care, patients must be seen within 6 months to obtain a refill.
- If your insurance company requests a 3 months mail-in order, please allow ample time for the order to be received through the mail. The patient is responsible to mail in the prescription.

Medical Records and Forms

- School Forms: must be filled out with the patient’s information by the parent. There is a \$10 fee and we require 7-10 business days for all forms to be completed.
- Written authorization from the patient/parent or guardian must be obtained to release medical records.
- Two Week’s notice is required to complete your request for medical records and/or the completion of forms.
- **A \$10.00 processing fee applies to the above requests, any records over 10 pages will be charged \$1.00 per page**

No Show and Cancellation Fee

- A 24-hour cancellation notice is required for all appointments. **A fee will be implemented if required notice is not given.**

**PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
A FEE OF \$25.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.**

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY INSURANCE AND/OR DEMOGRAPHIC CHANGES.

Office Policy is subject to change without notice.

I have read and understand the office policy and agree to abide by its guidelines.

Print Patient Name _____

Signature of patient or responsible party _____ Date _____

