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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 of pt 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** ____/____/____ 10/27/17

Princeton Allergy & Asthma Associates
New Patient (Respiratory / Nasal / Sinus)

Name___________________________ DOB___________________ Date_______________

Provider Comments
(please do not write in this space)

Briefly describe your main reason for seeing us today:_____________________________
____
____
____

How long have you had these problems? ______________________________________
How frequently do you have them? ____

Allergy History (Nasal Symptoms / Causes)

1. I have the following symptoms (circle all that apply and star the most troublesome one or ones):

Nasal Congestion	Nasal Itch / Rub	Bad Breath
Sneezing	Red Eyes	Snoring
Post Nasal Drip	Itchy Eyes	Mouth Breathing
Runny Nose	Sinus Infections	Nose Bleeds
Nasal Polyps	Discolored Drainage	Loss of Taste / Smell
Fatigue/Irritability	Headaches	Vocal Hoarseness

2. Circle all the things that cause your symptoms (circle all that apply and star the most troublesome):

Dust	Mold / Mildew	Time of day AM / PM
Fall Pollen	Mustiness / Dampness	Home
Springtime Pollen	Indoors / Outdoors	Workplace
Cut Grass / Raked Leaves	Temperature Changes	Food
Cat / Dog	Smoke	Rain
Other Animal	Weather Changes	
Feathers	Strong Odors	

3. Do your symptoms occur year round or seasonal? Circle one or both. If seasonal, months symptoms occur____
4. Have you had a sinus x-ray of CT scan? Yes No. When?_________________

Respiratory History

1. Circle any appropriate symptoms.

Cough	Cough from post nasal drip	tightness
Shortness of breath	Symptoms with exercise	wheeze

2. Breathing problems triggered by:

Pollen	Colds	Exercise	Pets
Sinus Infection	Mold	Heartburn	Foods_______
Weather Changes		Cold weather	Rain

3. Do you wake up at night because of breathing or chest symptoms? Yes No
4. Do you use albuterol (Proventil/Ventolin)? How often__________________
5. Circle any circumstances appropriate to your asthma.
   ER Visits________ Hospitalizations_______ Intubation ICU Admission
6. Have you been on steroids for your asthma? No Yes # of times___________
7. Have you had a chest x-ray? Yes No Last chest X-Ray_______________

Medications: (include inhalers and nasal sprays)

Name	Dose	Frequency	
________________	______________	________________	Daily / Often / Rarely
________________	______________	________________	Daily / Often / Rarely
________________	______________	________________	Daily / Often / Rarely
________________	______________	________________	Daily / Often / Rarely
________________	______________	________________	Daily / Often / Rarely

Vitamins ____
Over the counter ____

Name________________________________

Do you use a spacer? No Yes Which type?
Do you use a peak flow meter? No Yes Best Peak flow
Do you use a home nebulizer? No Yes

Provider Comments
(please do not write in this space)

Medication Allergy:

Drug	Reaction	Date

Allergy Evaluation History:
Had allergy skin tests? No Yes Date of testing? ____________________
Had allergy injections? No Yes Date of last injection? ____________________

General Medical History: Please circle as many that apply:

Hypertension	Heart Attack	Pneumonia	Glaucoma	Cataracts
Hypothyroidism	Arthritis	Heartburn	Ulcers	Diabetes
Irritable Bowl	Migraines	Hepatitis	Hyperthyroid	Emphysema
Liver Disease	Eczema	Seizures	Cancer	Anemia
Osteoporosis	Bronchitis	Depression	Other: ____________	

Review of Systems – Please circle as many that apply

Constitutional: Fever Weight Loss Weight Gain Fatigue Irritability
Eyes: Swelling Discharge Contact Lens Other:
Ears: Hearing Loss Recurrent Ear Infections Ear Congestion Ringing
Cardiac: Palpitations Chest Pain Leg Swelling Other: ________
GI: Nausea Vomiting Stomach Pain Diarrhea
GU: Pain on urination Blood Prostate problems Recurrent infections
Skin: Hives Swelling Itching Sores in mouth Thrush
Neurologic: Headaches Numbness Weakness
Musculoskeltal: Joint Swelling Bone Pain Child growing well?
Psychiatric: Allergies affecting quality of life? Yes No
Hematological: Swollen Glands Bleeding HIV Positive

Do you get a flu shot yearly? Yes No
Have you ever had a Pneumovax? Yes No
Have you had all your childhood vaccinations? Yes No

Surgery / Operations:
Which ones and what year? ______________________________
Ear Tubes Nasal / Sinus Surgery Tonsillectomy / Adenoidectomy
Others:

Other Allergies:
Do you have eczema or hives? Yes No
Have you ever had an allergic reaction to an insect sting? Yes No
If yes, what happened? ______________________________
Food Allergies:
Are you allergic to any foods?

Food	Reaction	Date

Have you ever had a reaction after using any of the following:
Balloons Condoms Rubber Products Elastic Bandages Gloves
Have you ever had itching, sneezing or swelling after Dental exam or GYN exam? Yes No

Name________________________________

Social History:

Do you smoke? No Yes Pks. Per Day __________ Years _______
Quit _________ Cigars No Yes How many per month? _____________

Your occupation? _____________________ Do you work: indoors outdoors both
Are symptoms worse at work? Yes No At school? Yes No
Did you miss school or work in the last year because of your allergies or asthma?
No Yes How many days? _____________________
If patient is a child, does he/she attend daycare? No Yes: In Home Commercial

Environmental Survey:
What type of residence do you live in?
Apartment House Condo Townhouse Trailer
How old is your home? ______ How long have you lived there? ________

Do you have an Air Conditioner? No Yes: Window Central Bedroom Only? Yes No

What kind of heating do you have? Baseboard Forced Air Hot Water Space Heater

Are your windows closed during allergy season? No Yes

Do you have a humidifier? No Yes: Central/Room/Both

Do you have an air filter? No Yes: HEPA Electrostatic Central/Room/Both

Do you have moisture problems in your house? No Yes, whole house Yes, basement only

Do you have carpeting? No Yes: Whole house bedroom bedroom and den

Do you have feather bedding? No Yes: Pillows Comforter & Pillows
Do you have allergen encasements? No Yes: Pillows Mattress & Pillows

Do you have stuffed animals? No Yes: a few several many too many to count

Do you have pets? No Yes How many? ______ What kinds? __________________
Do the pets go into the bedroom? No Yes Do they go on the bed? No Yes

Other: ____

Family History: Mother Father Brother Sister Children Grandparents
Family Member: **Condition:**
____
____
____
____

Patient / Guardian Signature:______________________________

Date:_______________

Dr. Signature____

Provider Comments
(please do not write in this space)

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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**_________

Princeton Allergy & Asthma Associates
HIPAA Disclosure Information of Protected Health Information

Patient Name: ______________________________________ **Date of Birth:** ____________

This authorization is given by: ___ **The Patient** ___**Parent/Guardian** __________________
Print Name

The physicians/practice may disclose to:

____**Any medical provider/facility** ___**Spouse**___________________________
Print Name

____**Parent**________________________ ___**Children**__________________________
Print Name Print Name

____**Other**_________________________ ____________________________________
Print Name Relationship

This authorization in effect until: (MUST check one)

____ It is revoked in writing
____One Year

____ Date__________________________
Signature of Patient or Parent/Guardian
10/27/17