

# Princeton Allergy and Asthma Assoc., P.A.

## Patient Information Please use BLACK PEN ONLY & PRINT Account # \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_  
Contact in an emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about us:** Physician \_\_\_ Friend \_\_\_ Name of Friend \_\_\_\_\_  
Insurance \_\_\_ Newspaper \_\_\_ Internet \_\_\_ Yellow Pages \_\_\_ Family \_\_\_ Other \_\_\_\_\_  
Referring Physician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party Information (for minors under the age of 18)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_  
Relationship: Mother \_\_\_ Father \_\_\_ Employer \_\_\_ Legal Guardian \_\_\_ Other \_\_\_

## Insurance Information

Primary Insurance: \_\_\_\_\_  
Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Subscriber First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Relation of patient to subscriber: Self \_\_\_ Spouse \_\_\_ Son \_\_\_ Daughter \_\_\_ Other \_\_\_  
Employer \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_  
Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date \_\_\_\_\_  
Subscriber First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Relation of patient to subscriber: Self \_\_\_ Spouse \_\_\_ Son \_\_\_ Daughter \_\_\_ Other \_\_\_

**Any other insurance?** \_\_\_\_\_

## Authorization & Release

Please list any person(s) to whom we may release medical information \_\_\_\_\_  
I authorize the release of any medical or other information necessary in the processing my claims. I also request the release of payment be made directly to Princeton Allergy & Asthma Associates, P.A.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Would you like information on the benefits of participation in Clinical Research? Yes \_\_\_ No \_\_\_

**If Yes**, please read the following statement and sign below:

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.

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** \_\_\_\_\_

5/14/2008 For office use only: Initial \_\_\_\_\_ Date \_\_\_\_\_

Briefly describe your main reason for seeing us today: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider Comments  
 (please do not write in this space)

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 or 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 \_\_\_\_\_

9/06

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**

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

Provider Comments  
(please do not write in this space)

**Smoking History:** Yes No Pks. Per Day \_\_\_\_\_ Years \_\_\_\_\_  
Quit \_\_\_\_\_ Cigars Yes No How many per month? \_\_\_\_\_

**Occupation History:**

Your occupation? \_\_\_\_\_  
Symptoms worse at work? Yes No Better on vacation? Yes No  
Did you miss school or work in the last year because of your allergies or asthma?  
No Yes How many days? \_\_\_\_\_  
Exposure to fumes or chemicals? No Yes  
Exposure to animals? No Yes Which ones? \_\_\_\_\_  
How long have you lived in NJ? \_\_\_\_\_  
Hobbies: \_\_\_\_\_

**Environmental Survey:**

Apartment House Condo Townhouse Trailer  
How long have you lived there? \_\_\_\_\_ How old is it? \_\_\_\_\_  
Air Conditioner? No Yes Window Central  
Do you have a humidifier? No Yes Central or Room  
Do you have an air filter? No Yes HEPA Electrostatic Central or Room  
Do you have moisture problems in your house? No Yes  
Do you get water in the basement or is it damp? No Yes  
Type of Bed: Regular Age of mattress: \_\_\_\_\_ Waterbed  
Pillows: Feather Synthetic Cotton Down  
Flooring in Bedroom: Carpet Hardwood Tile Vinyl  
Pets: \_\_\_\_\_ Do they go into the bedroom? Yes No  
Do you keep your windows closed during the pollen season? Yes No  
Window treatments in the bedroom? Shades Curtains Blinds Drapes  
Other: \_\_\_\_\_  
Stuffed animals in the bedroom? No Yes How many? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient / Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Dr. Signature** \_\_\_\_\_



# PRINCETON

ALLERGY & ASTHMA ASSOCIATES, P.A.

## Payment Policy

D. Loren Southern, M.D.  
Andrew J. Pedinoff, M.D.  
Julie A. Caucino, D.O.  
Helen S. Skolnick, M.D.  
Kristen M. Sikorski, M.D.

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.

**Princeton**  
24 Vreeland Drive  
Skillman, NJ 08558  
Phone: (609) 921-2202  
Fax: (609) 924-1468  
www.princetonallergy.com

**Plainsboro**  
666 Plainsboro Road  
Building 100 B  
Plainsboro, NJ 08536  
Phone: (609) 799-8111  
Fax: (609) 799-2522

**Hamilton**  
1245 Whitehorse Mercerville Rd  
Building A, Suite 421  
Hamilton, NJ 08619  
Phone: (609) 888-1555  
Fax: (609) 888-1126

**Flemington**  
5 Walter E. Foran Blvd.  
Town Centre Professional Park  
Suite 2000  
Flemington, NJ 08822  
Phone: (908) 782-0093  
Fax: (908) 782-3521

**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. 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.

**3. 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.

**4. 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.

**5. 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.

**6. 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.

**7. 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.

**8. 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 non-payment, PAAA may, in addition to the invoice charges and service fee, charge debt collection and/or legal fees incurred by PAAA in relation to the recovery of outstanding amounts. 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.

*Payment Policy 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** \_\_\_\_\_

1/9/08

**Please sign both sides. Over →**

## 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 with your pharmacy if any refills are present. We require 48 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 month 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

- Written authorization from the patient/parent or guardian must be obtained to release medical records.
- One 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.**

### 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 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, P.A.

## ACKNOWLEDGEMENT

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Kristen M. Sikorski, M.D.

I, \_\_\_\_\_, acknowledge that I have received a copy of Princeton Allergy & Asthma Associates P.A. Notice Regarding Privacy of Personal Health Information.

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

## CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_ (Patient Name), of \_\_\_\_\_ (Address), give to Princeton Allergy & Asthma Associates P.A. my consent to use and disclose any and all protected health information created by Princeton Allergy & Asthma Associates P.A. and/or maintained in my medical record (defined to include all medical reports, diagnosis, clinical abstracts, case histories, proposed treatment plans and prognosis, x-ray reports, insurance information and/or any other information) as necessary to carry out treatment, payment or health care operations.

I understand that a complete description of the uses and disclosures that may be made of my Health Information are set forth in Princeton Allergy & Asthma Associates Notice of Privacy Practices. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices is subject to change, and that if there is a change, Princeton Allergy & Asthma Associates P.A. will provide me with a revised copy.

I understand that Princeton Allergy & Asthma Associates P.A. may refuse to provide treatment to me if I do not execute this consent. I further understand that I have the right to request that Princeton Allergy & Asthma Associates P.A. restrict how my medical record is used or disclosed to carry out treatment, payment, or health care operations. However, Princeton Allergy & Asthma Associates P.A. is not required to agree to my requested restrictions. If Princeton Allergy & Asthma Associates P.A. does not agree to my requested restrictions, such restrictions will be binding.

I understand that the specific information released may contain information in reference to alcohol/drug abuse, sexually transmitted diseases, HIV/Aids infection and/or psychiatric conditions and the treatment of these disorders.

I understand that the terms of this consent are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this consent, at any time, except to the extent that Princeton Allergy & Asthma Associates P.A. has taken action in reliance thereon. I understand that any revocation must include my name, address, telephone number, date of this consent and my signature and that I should send it to:

**Princeton Allergy & Asthma Associates P.A.**  
**24 Vreeland Drive**  
**Skillman, NJ 08558**

Patient Name \_\_\_\_\_

Patient Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient/Representative Signature \_\_\_\_\_ Date of Consent \_\_\_\_\_

3/18/09

**Princeton**  
24 Vreeland Drive  
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666 Plainsboro Road  
Building 100 B  
Plainsboro, NJ 08536  
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**Hamilton**  
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5 Walter E. Foran Blvd.  
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