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**_____

Cell Phone (_____) _____ Ok to leave extended message? Yes No (cell # must be parent's if patient is under 18)

Add'l or Home 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 to release medical information to _____**Relationship** _____**Phone** (____) _____

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** ____/____/____ 4/14/21

PRINCETON
ALLERGY & ASTHMA ASSOCIATES, P.A.

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K. Sikorski, M.D. S. Shah, M.D N. Baman, M.D.

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

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.

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

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
A FEE OF $35.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

***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_____

Please sign both sides. Over →

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Office Policy

All Patients

- All patients under 18 years of age must be accompanied by their parent or guardian.
- If you have labwork done and would like a copy of the results, we ask that you obtain them from the lab. We will provide information for retrieving them from the lab website. There may be a charge to have us copy them for you.
- Patients receiving allergy injections **must** wait 30 minutes before leaving our facility.

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.

Allergy & Patch testing:

- Allergen skin testing and patch testing are routine procedures done in our office. These aid in the diagnosis and management of your condition.
- The risks of these tests are very minor and may include local redness/rash and swelling at the site. Rarely, anaphylaxis can occur related to allergen skin testing. In the event of a reaction, you may receive treatment with any of the following medications including Benadryl (oral or topical), steroids (oral or topical) and in rare cases, epinephrine.

Prescription refills

- **BEFORE CALLING OUR OFFICE FOR A REFILL, PLEASE CHECK WITH YOUR PHARMACY to find out if any refills are present.** If no refills are present please have your pharmacy contact us. You may also request a refill through the patient portal on our website. 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 or Camp 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 weeks' notice is required to complete your request for medical records and/or the completion of school or camp forms.
- **A $10.00 processing fee applies to the above requests and any records over 10 pages will be charged $1.00 per page.**

No Show and Cancellation Fee

- A 48-hour cancellation notice is required for all appointments. **A fee may be implemented if required notice is not given or if you fail to show for your appointment.**

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_____

8/20/20

Please sign both sides. Over →

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** (Sending medical records will still require a written request with a signature)

____**Spouse**_____ ___**Child(ren)**_____
Print Name Print Name

____**Parent**_____ _____
Print Name Print Name

____**Other**_____ _____
Print Name Relationship

We offer helpful administrative information by regular text messaging and email (**ie appointment reminder, refill info**). There is some level of risk that information on your phone/computer could be read by someone besides you. Please indicate preferences below.

EMAIL

___ YES – You may communicate with me by **email**. My email address is _____.
I will notify you right away if my email address changes
___ NO - Please do NOT communicate with me by regular email.

CELL PHONE (text messaging used for appointment confirmations, appointment check-in, prescription notifications, etc.)

___ YES – You may communicate with me by **text message**. My cell phone # is _____.
I will notify you right away if my cell phone number changes
___ NO - Please do not communicate with me by regular text message.
*We confirm most appointments via text

This authorization in effect until revoked in writing.

_____ Date_____
Signature of Patient or Parent/Guardian 3/3/20

New Patient History

Patient Name _____ Date _____

List current & past medical history:

_____

_____

_____

List current medications & doses:

List past surgeries:

_____

_____

_____

Known drug allergies: _____

Pharmacy: Local_____ Mail order: _____

2/24/20

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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 asthma, please bring inhalers.**
- **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)
- All attached New Patient forms - completed.
- If appointment is with Dr Caucino, Dr Skolnick, Dr Sikorski, Dr Shah or Dr Baman, please complete the medical questionnaire on your patient portal. (link found directly below your appointment information) You should have received temporary login information or a link for your patient portal via email after making your New Patient appointment. If you did not receive it, please call for new temporary login information.

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Kristen M. Sikorski, MD Shaili N. Shah, MD Neil S. Baman, MD
609-921-2202

ALLERGY SKIN TESTING AND MEDICATIONS

Several medications interfere with allergy skin testing. If you would like to be skin tested, please follow the recommended time intervals listed below for allergy medications that would need to be stopped for accuracy. **Please do not stop any chronic medications.** The nurse will ask you what medications you are taking, **so please have a complete list when you come to the office**. If you have severe allergy or asthma symptoms you may not be tested for safety reasons. It will be done at the discretion of your physician.

DO NOT STOP ANY OF THE FOLLOWING CHRONIC MEDICATIONS TO TREAT OTHER CONDITIONS
(EXAMPLES LISTED BELOW)

Blood pressure medications
Antibiotics
Antidepressants
Inhalers for asthma or COPD
Oral steroids
Thyroid medications
All asthma medications
Cardiac (heart) medications
Psychiatric medications

The following categories of Medications **need** be Stopped **5 days** Before Skin Testing with a few **7-day** exceptions as noted.

This list may not be complete, since new medications come on the market frequently, so please call us with any questions:

1. **Older Allergy Medications**

Benadryl (diphenhydramine)	Ru-Tuss, Triaminic (pheniramine)
Trinalin (azatadine)	Polaramine (tripelenamine)
Actifed (triprolidine)	Dimetapp, Dimetane, Bromfed (brompheniramine)
Chlor-Trimeton (chlorpheniramine)	Periactin (cyproheptadine)

2. **Non-Sedating Allergy Medications**

Claritin, Alavert (loratadine) **(7days)**	Allegra (fexofenadine)
Clarinex (desloratadine) **(7days)**	Zyrtec (cetirizine)
Xyzal (levocetirizine) **(7days)**	

3. **Over-the-Counter Cold, Sinus, and cough Medications**

Phenergan Cough Syrup (promethazine)	Alleve Cold
Advil Cold/Sinus	Alka-Seltzer Plus/Cold
Comtrex	Contact
Coricidin	Drixoral
Pediacare	Rondec
Rynatan	Sinutab
Theraflu	Triaminic
Tylenol Cold/Sinus	Sudafed Allergy
Semprex D	Anything else with "PM" or "Allergy" in the name

4. **Medications for Itching and Hives**
   Atarax, Vistaril (hydroxyzine)

5. **Medications for Nausea and Motion Sickness**
   Antivert, Bonine (meclizine)
   Dramamine (dimenhydrinate)

6. **Over-the-Counter Sleeping Medications**

Advil PM	Excedrin PM
Sominex	Nyquil
Tylenol PM	Anything else with "PM"

7. **Allergy Nasal Sprays**
   Patanase (olapatidine) **(Dr. Sikorski patients stop 7days prior)**
   Astelin, Astepro (azelastine) **(Dr. Sikorski patients stop 7days prior)**
   Dymista (azelastine) **(Dr. Sikorski patients stop 7days prior)**
   All others are not a problem

The following drugs should NOT be discontinued,
but please tell the nurse if you are taking any of them:

Norpramin (desipramine)	Sinequan (doxepin)
Tofranil (imipramine)	Remeron (mirtazapine)
Zyprexa (olanzapine)	Xanax (alprazolam)
Benzodiazepines	