PRINCETON
ALLERGY & ASTHMA ASSOCIATES, P.A.

**D. L. Southern, M.D. J. Caucino, D.O. H. Skolnick, M.D. S. Shah, M.D**
**K. Sikorski, M.D. A. Pearlstein, D.O. Jacqueline Chapkowski, APN-C**

**Princeton 609-921-2202 Plainsboro 609-799-8111 Hamilton 609-888-1555**
**Flemington 908-782-0093 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.**
- Several medications interfere with allergy skin testing. If you would like to be skin tested, please follow the recommended time intervals listed on the medication avoidance list attached 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 including over-the-counter** medications. 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. Please wear short sleeves.
- If you use inhalers, please bring them to your appointment.
- 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 Check in process on cell phone by clicking the link in the text you received 1 week prior or 2 hours prior to appointment. May also check in on the kiosk in office rather than on cell phone if preferred.
- Completed medical questionnaire on your patient portal no sooner than 1 wk prior to appointment. (Portal setup: see 2nd link in email received after scheduling initial appointment; Link for questionnaire is found directly below your appointment info on your portal 1 wk prior to appointment or in confirmation text)
- If you are going to the Plainsboro office, please enter our NAME into your GPS rather than our address. This will bring you directly to our door. Using our address makes it difficult to find our office.

# 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** (_____) _____ (cell # must be parent's if patient is under 18)

**Add'l Phone** (_____) _____Home__ Cell__

**Marital Status**? Single Married Divorced Widow **SS #** _____

**Email Address**_____

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

**Referring Physician** _____ **Address** _____ Ph**one**(____)_____

**Primary Care Physician** _____ **Address** _____ **Phone** (___) _____

**Emergency Contact we may release medical information to:**

**Name** _____ **Relationship** _____ **Phone** (_____) _____

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

**Name** _____ **Date of Birth** ____/____/___ **Sex** M F

**SS#**_____ **Relationship:** Parent Legal Guardian Other _____ **Marital Status**? S M D W

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

**Home Phone** (____)_____ **Cell Phone** (____)_____ **Work Phone** (___)_____

**INSURANCE INFORMATION** .

**PRIMARY INSURANCE:** _____ **ID#**_____ **Group** #_____

**Effective Date**___/___/___ **Relationship of patient to insured** Self Spouse Child Other____

**Subscriber** _____ **Date of Birth** _____/_____/_____ **Sex** M F

**Street Address (if different from patient)** _____ **City**_____

**State**_____ **Zip**_____ **Home Phone** (____) _____ **Cell Phone** (____) _____

**SECONDARY INSURANCE:** _____ **ID#** _____ **Group** #_____

**Effective Date**___/___/___ **Relationship of patient to insured** Self Spouse Child Other____

**Subscriber** _____ **Date of Birth** _____/_____/_____ **Sex** M F

**Street Address (if different from patient)** _____ **City**_____

**State**_____ **Zip**_____ **Home Phone** (____)_____ **Cell Phone** (____)_____

**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** _____/_____/_____ 8/15/23

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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.

**10. Allergy Injection Patients:** Your allergy serum has different concentrations with different expiration dates. If you are noncompliant with your injection schedule and your serum has expired, we will have to re-dilute your serum. The cost of re-diluting serum has markedly increased. Princeton Allergy and Asthma will absorb the expense of re-dilution one time only. Going forward the cost of $50.00 will be the patient's responsibility.

**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.

Allergy Serum:

- Your allergy serum has different concentrations with different expiration dates. If you are noncompliant with your injection schedule and your serum has expired, we will have to re-dilute your serum. The cost of re-diluting serum has markedly increased. Princeton Allergy and Asthma will absorb the expense of re-dilution one time only. Going forward the cost of $50.00 will be the patient's responsibility.

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 $15 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 $15.00 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 payment policy and agree to abide by its guidelines.**

**Print Patient Name** _____

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



**Please sign both sides. Over →**

# Princeton Allergy & Asthma Associates

**HIPAA Disclosure Information of Protected Health Information**

**This authorization is given by:** _____ **The Patient** _____**Parent/Guardian** _____

**The physicians/practice may disclose to:**

____ **Any medical provider/facility** (Sending medical records will still require a written request with a signature)

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

____ **Other**_____
Print Name Relationship

We offer helpful administrative information by regular text messaging and email (**ie: check in process, 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 immediately if my email address changes.
___ NO - Please do NOT communicate with me by regular email

## CELL PHONE

___ YES – You may communicate with me by **text message**. My cell phone # is _____.
I will notify you immediately 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.**

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** ____/____/____

# Princeton Allergy & Asthma
# New Patient History

Patient Name _____ Date _____

List current & past medical history:

_____

_____

_____

List current medications & doses: (please include over-the-counter medications)

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List past surgeries:

_____

_____

_____

Known drug allergies: _____

Pharmacy: Local_____ Town: _____ Mail order: _____

**Princeton Allergy and Asthma Associates, P.A.**
**Phone: 609-921-2202 Fax: 609-924-1468**

**Appointment Date/Time:** _____ **PR PL HM FL**

# ALLERGY SKIN TESTING AND MEDICATIONS (please wear short sleeves)

For **NEW PATIENT VISITS**: 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 able to 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

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

The following medications **need** to be **STOPPED 5 DAYS** Before Skin Testing (**with a few 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 5 DAYS**

| | | |
|---|---|---|
| Benadryl (diphenhydramine) | Ru-Tuss, Triaminic (pheniramine) | Chlor-Trimeton (chlorpheniramine) |
| Polaramine (tripelenamine) | Actifed (triprolidine) | Dimetapp, Dimetane (brompheniramine) |
| Nolahist, Nolamine = phenindamine | Trinalin (azatadine) | Bromfed (brompheniramine) |
| **Periactin (cyproheptadine) 9 DAYS** | | |

2. **Non-Sedating Allergy Medications (7 DAYS)**

| | | |
|---|---|---|
| Claritin, Alavert (loratadine) | Allegra (fexofenadine) | Clarinex (desloratadine) |
| Zyrtec (cetirizine) | Xyzal (levocetirizine) | |

3. **Over-the-Counter Cold, Sinus, and cough Medications 5 DAYS**

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

4. **Medications for Itching and Hives 5 DAYS**
   Atarax, Vistaril (hydroxyzine)

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

6. **Over-the-Counter Sleeping Medications 5 DAYS**

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

7. **Allergy Nasal Sprays 14 DAYS**

| | | |
|---|---|---|
| Patanase (olapatidine) | Astelin, Astepro (azelastine) | Dymista (azelastine, fluticasone) |
| Ryaltris (olopatadine, mometasone furoate | | All others are not a problem |

8. **Reflux/Stomach medications 5 DAYS**
   Axid (nizatidine) Pepcid (famotidine) Tagamet (cimetidine) Zantac (ranitidine)

9. **Allergy Eye Drops 7 DAYS**

| | | | |
|---|---|---|---|
| Bepreve (bepotastine besilate) | Elestat (epinastine HCl) | Lastacaft (alcaftadine) | Livostin (levocabastine HCl) |
| Optivar (azelastine HCl) | Pataday (olopatadine HCl) | Zaditor (ketotifen fumarate) | Zerviate (cetirizine) |

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

| | | | |
|---|---|---|---|
| Norpramin (desipramine) | Sinequan, Deptran (doxepin) | Tofranil (imipramine) | Remeron (mirtazapine) |
| Zyprexa (olanzapine) | Xanax (alprazolam) | Celexa (citalopram) | Ativan (lorazepam) |
| Benzodiazepines | | | |

**Intranasal steroid sprays will not interfere with testing:**
Flonase (fluticasone), Nasonex, Zetonna, Nasacort (triamcinolone), Rhinocort, QNASL 6/20/23