NY Food Allergy & Wellness

Atul N. Shah, MD, FACAAI, FAAAAI
Daniel L. Mayer, MD, FAAAAI
Janet E. Kelske, MS, CPNP, ANP-C, AE-C
Paola Spicer Soto, MS, PA-C
Patricia A. Lombardi, PA-C

.

Dear Patient,

Welcome to our practice!

To facilitate your first visit to our office, attached is our "intake" paperwork so that you may review and complete before your visit. For your convenience, you can either fax the completed paperwork along with your ***insurance card*** *or you may bring it with you.*

If you have any blood work, hospital records or skin tests, please bring a copy of the results with you.

See the attached list of medications that should be stopped prior to your visit if skin testing is necessary.

If your insurance plan requires you to have a referral to see a specialist, you must coordinate getting that referral from your primary care physician ***before*** *your appointment with us.* ***All copayments, by contract with the insurance companies, must be paid at the time of your visit.*** *We reserve the right to charge an additional service charge – currently $10.00 – for any unpaid copayment on the date of service. For your convenience, we accept cash, check, credit/debit cards. It is your responsibility as the patient/insured, to be aware of the current terms of your insurance coverage****. Self-pay patients****- Payment is expected at the time of service.*

*We confirm all appointments, so we appreciate a call 24 hours prior to your exam if you will need to cancel or reschedule****. Any appointment not canceled within 24 hours will be subject to a $25.00 invoice mailed to your home.***

Divorced/Separated parents of minor patients- The parent who consents to the treatment of a minor child is responsible for the service charges.

With your cooperation and assistance, you should receive all the benefits offered to you and we will be able to concentrate on caring for medical needs.

I understand the office policy stated above and agree to accept responsibility as described above.

Patient Signature: _____ Date: _____
(If minor, parent signature)

Print Patient Name: _____

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Patient Information

Patient's Last Name:_____ First Name:_____ MI:____ Date of Birth:_____

Patient SS# :_____ Sex: M / F Parent /Guardian(If Minor):_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-mail Address:_____ Marital Status: ___S ___M ___D ___W

Primary Care Physician:_____ Address:_____ Phone:_____

Pharmacy Name, Location, & Phone: _____

Patients Occupation: _____ Employer: _____

Insurance Information – Primary Medical Insurance

Policy Holder's Name: _____ Relationship: _____ DOB: _____ SS#:_____

Insurance Plan Name: _____ Policy ID:_____ Policy Group:_____

Employer: _____ Referral Needed?: ___YES* ___NO Effective Date: _____ Copay: _____

*As a patient/parent, you understand that if a referral is required, it is your responsibility to obtain a referral and provide our office with that document for the services provided by this practice. You are aware and understand that if a referral is **not** obtained, you will be responsible for the charges of services rendered by our medical practice. ____ Initial of Parent/Patient (if minor)

Secondary Insurance? ___ Yes** ___ No **If yes, please indicate the following

Policy Holder's Name: _____ Relationship: _____ DOB: _____ SS#:_____

Insurance Plan Name: _____ Policy ID:_____ Policy Group:_____

Assignment of Benefits and Release of Information

I authorize my insurance benefits to be paid directly to Atul N. Shah, MD, PC for all the medical services rendered. I understand that I am responsible for any account balance for medical services rendered that my insurance does not cover. I certify that the information I have reported with regard to my insurance is correct and accurate. I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. I will notify you of any changes in the above information. I understand my rights under the HIPAA Privacy Laws and have been given the opportunity to ask questions about this notice and I can request a copy of the Notice of Privacy Practices.

Signature of Patient: _____ Date: _____
(Parent if minor)

Patient Name: _____ Age: _____ DOB: _____ Date: _____

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Patient Intake

Name: _____ Age: _____ DOB: _____ Date: _____

Sex: M / F Height: _____ Weight: _____ Last Dose of Antihistamine: _____

Whom may we thank for referring you?: _____ Primary Care Provider: _____

Present Illness (HPI):
Reason for Visit/Current symptoms: _____

Environmental Allergies:
Have you ever been diagnosed with Environmental Allergies? Y / N If yes, which?: Indoor / Outdoor / Both

Food Allergy:
Do you have Food Allergies?: Y / N If yes, list foods & reactions: _____
_____
Previous Food Challenges? Y / N If yes, list food and location: _____
Previous Oral Immunotherapy? Y / N If yes, list food and location: _____

Drug Allergy: Y / N If yes, specify drug(s) & reaction: _____
Latex Allergy: Y / N If yes, specify reaction: _____
Stinging Insect Allergy: Y / N If yes, specify insect(s) & reaction: _____
Did the reaction go beyond local site of sting? Y / N If yes, describe: _____

Immunology/Infections:
Do you get recurrent upper/lower respiratory infections (Sinusitis, Bronchitis, Pneumonia, etc.) Y / N
How often are you treated with antibiotics?: _____ Last dose of antibiotics?: _____

Do not write in this area

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Patient Name:_____ DOB:_____ Date:_____

Asthma:
Have you ever been diagnosed with Asthma or "Reactive Airways" or treated with inhalers/nebulizer? Y / N
Have you ever been treated with oral steroids (Prednisone, Medrol) in the past year?: _____
Have you ever needed ER visits or hospitalization for Asthma? Y / N If yes, last visit: _____

Eczema:
Have you ever been diagnosed with Atopic Dermatitis (Eczema)? Y / N
Have you ever been diagnosed with Contact Dermatitis? Y / N

Immunizations:
Have you had the Pneumonia vaccine? (Prevnar, Pneumovax): Y / N If yes, when: _____
Do you get Flu vaccines? Y / N If yes, last received (Month/Year)?: _____
Did you get the COVID-19 Vaccine? Y / N If yes, which: _____ When: _____ Boosted: _____
Are you up to date with other immunizations? Y / N If no, specify: _____
Any reactions to vaccines? Y / N If yes, which vaccine and reaction: _____

Current Home Environment:
Type of Heating: Radiator / Baseboard / Forced Hot Air / Wood Burning Stove / Pellet Stove
Air Conditioning? Y / N If yes, what kind: _____
Basement?: Y / N If yes, is it finished?: Y / N Ever flooded?: Y / N Is it damp or musty?: Y / N
History of mold or mildew in your home?: Y / N Carpeting in the bedroom?: Y / N
Pets: Y / N If yes, what kinds?: _____ Do they sleep in the bedroom?: Y / N

Social History:
____ Non Smoker
____ Smoker: for how many years?: _____ Cigarettes / Pipe / Vape / Cannabis
____ Former Smoker
Is there any secondary smoke exposure? Y / N
Occupation: _____ Work exposure:_____

Females: Are you pregnant?: Y / N

Past Medical & Surgical History:

_____
_____
_____
_____
_____
_____
_____
_____
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_____

Current Medications, Dose, & Frequency:

_____
_____
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_____
_____

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Patient Name:_____ DOB:_____ Date:_____

Does any of this apply to you?

Constitutional:
- Weight loss Yes / No
- Sudden weight gain Yes / No
- Loss of appetite Yes / No
- Fever Yes / No
- Chills Yes / No
- Night sweats Yes / No
- Fatigue/Tiredness Yes / No

Eyes:
- Blurred vision Yes / No
- Double vision Yes / No
- Swelling Yes / No
- Redness Yes / No
- Itching Yes / No
- Watering Yes / No

Nose/Sinuses:
- Sneezing Yes / No
- Itching Yes / No
- Congestion Yes / No
- Postnasal drainage Yes / No
- Runny nose Yes / No
- Snoring Yes / No
- Nasal polyps Yes / No
- Sleep problems Yes / No
- Sinus headaches Yes / No
- Decreased smell Yes / No
- Nose bleeds Yes / No
- Bad smell Yes / No
- Sinus pressure Yes / No
- Frequent infections Yes / No

Throat/Mouth:
- Sore throat Yes / No
- Post nasal drip Yes / No
- Frequent infections Yes / No
- Difficulty swallowing Yes / No
- Swollen glands Yes / No
- Bad breath Yes / No

Ears:
- Itching Yes / No
- Fluid/Popping Yes / No
- Hearing loss Yes / No
- Ringing Yes / No
- Frequent infections Yes / No

Cardiovascular:
- Fast heart beat Yes / No
- Chest pain Yes / No
- Angina Yes / No
- Murmur Yes / No
- Heart attack Yes / No
- Edema/Swelling Yes / No

Endocrine:
- Thyroid disease Yes / No
- Diabetes Yes / No
- Other: _____

Lungs:
- Wheezing Yes / No
- Shortness of breath Yes / No
- Shortness of breath with exertion Yes / No
- Cough Yes / No
- Chest tightness Yes / No

Gastrointestinal:
- Indigestion/Heartburn/GERD Yes / No
- Nausea/Vomiting Yes / No
- Diarrhea Yes / No
- Change in Bowel habits Yes / No
- Cramps/Pain Yes / No
- Bloating Yes / No
- Gas Yes / No

Urogenital - Kidney & Bladder:
- Burning with urination Yes / No
- Increased frequency of urination Yes / No
- Yeast infection Yes / No
- Prostate enlargement Yes / No

Musculoskeletal
- Back pain/ Bone pain Yes / No
- Muscle soreness Yes / No
- Arthritis Yes / No
- Lymes Disease Yes / No

Emotions/Psych:
- Irritability Yes / No
- Depression Yes / No
- Anxiety Yes / No

Hematological/Lymphatic:
- Easy bruising Yes / No
- Bleeding Yes / No
- Swollen glands Yes / No
- Anemia Yes / No
- Cancer Yes / No

Neurological:
- Numbness/Tingling Yes / No
- Migraines/Headaches Yes / No
- Dizziness Yes / No

Skin:
- Rashes/Hives Yes / No
- Eczema Yes / No
- Itching Yes / No
- Skin Infections Yes / No
- Hair loss Yes / No
- Dry skin Yes / No
- Poison Ivy Yes / No
- Psoriasis Yes / No

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Patient Name:_____ DOB:_____ Date:_____

Family Members Medical History:

Asthma: ___Mom ___Dad ___Sibling ___Grandparents ___Children ___Other
Hay Fever: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Food Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Drug Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Eczema: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Hives: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Animal Allergy: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Sinus Problems: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other
Other Illnesses: ___Mom ___Dad ___Sibling ___ Grandparents ___Children ___Other

Anything else we need to know?:

_____
_____
_____
_____
_____

For Office Use Only: History has been reviewed with this patient: _____
Date: _____

Do not write in this area

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PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

Please review and agree that:

- We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payers pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for Knowing and Understanding their own Insurance Policy, Eligibility and Coverage.
- Patients are responsible for payment of outstanding Deductibles and Coinsurance. Co-payments will be collected at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Any appointment, including allergy testing, missed or not canceled more than 24 hours in advance will incur a $25.00 charge.
- Returned checks are subject to a $35.00 fee.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.
- I understand that should it become necessary to take legal action to collect any outstanding balance after 180 days of non-payment, there will be an **additional 30% late fee** added to my delinquent balance.

The Patient or Patient's Legal Representative hereby acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician and Practices accordingly.

_____ _____

Patient Name | Date of Birth

_____ _____

Signature of Patient or Guardian | Date

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Notice of Privacy Practices

Center for Asthma & Allergy/ NY Food Allergy & Wellness Center's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the Center for Asthma & Allergy/ NY Food Allergy and Wellness Center's office manager.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This revised information supersedes any previous version of our privacy practices notifications. Any previous written instructions submitted under our previous policy need to be resubmitted in writing under this revision.

I hereby authorize the following individuals to interact with employees of Center for Asthma & Allergy/ NY Food Allergy and Wellness Center, to receive and provide Protected Health Information regarding me. This listing shall remain in effect until revoked in writing by me. (Please check more than one if needed.)

____ Myself only

____ Parent(s)/Guardian(s) *(if patient is a minor)*:_____

____ My Spouse:_____

____ My Adult Child(ren):_____

____ The Following Friends and/or Family:_____

For minor children: I am the custodial parent/guardian of _____ and I may legally receive this information.

I have read and reviewed the Center for Asthma & Allergy and NY Food Allergy & Wellness Center's Notice of Privacy Practices.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT :_____ NAME (GUARDIAN): _____

NY Food Allergy & Wellness
23 South Howell Avenue Suites O & P
Centereach, NY 11720
Phone 631-446-1436 ▪ Fax 631-446-1437

NY Food Allergy & Wellness
ParkSixty Medical
110 E 60th Street Suite 708
New York, NY 10022

Center 4 Asthma & Allergy
2 Coraci Blvd. Suites 13 & 14
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Please be aware if you are on any of the following medications.
***You MUST** be off them **5-7 days** prior to any Allergy Testing.*

Prescription Antihistamines	Non-Prescription Antihistamines
- AlleRx - Astepro/Astelin (Azelastine) Nose Spray - Doxepin - Dymista Nose Spray - Hydroxyzine (Atarax/Vistaril) - Karbinal ER (Carbinoxamine) - Meclizine (Antivert) - Naldecon - Patanase (Olopatadine) Nose Spray - Periactin (Cyproheptadine) - Phenergan (Promethazine) - RyClora (Dexchlorpheniramine) - RyVent (Carbinoxamine) - Rynatan - Tussionex - Tussi-12 **PLEASE NOTE: The above list may not be comprehensive. Please double check all over the counter medications you are taking, especially sleep aids, to ensure they do not contain antihistamines. If you are uncertain, please check with us.**	- Actifed - Advil Allergy Sinus/ PM/Cold & Flu PM - Alka-Seltzer Plus Sinus Allergy - Allerest - A.R.M. Allergy Relief - BC Cold Powder Multi Symptom - Benadryl (Diphenhydramine) - Cetirizine (Zyrtec, Zyrtec-D, & other brands) - Chlor-Trimeton (Chlorpheniramine) - Comtrex Multi-Symptom - Coricidin - Dimetane - Dimetapp - Drixoral - Fexofenadine (Allegra, Allegra-D, etc.) - Loratadine (Claritin, Claritin-D, etc.) - Motrin Allergy Sinus/PM/Cold & Flu PM - Midol - Nyquil - Pamprin - Pediacare Night Rest - Percogesic - Robitussin Night Time Cold - Sinarest - Sudafed Plus - Tavist - Triaminic Allergy - Tylenol Allergy Sinus/PM/Cold & Flu PM If any OTC meds are for Cold & Sinus, Sleep Aids, or Influenza, please also avoid.

The following Medications you must be off for **7 days** prior to any Allergy Testing

- Levocetirizine (Xyzal)
- Desloratadine (Clarinex)
- Prednisone
- Medrol Dose Pack
- Dexamethasone
- Decadron Elixir
- Orapred
- Prednisolone

****All topical steroid preparations are OK****

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