ALLERGY & ASTHMA CONSULTANTS PC
4104 Old Vestal Rd, Suite #108
Vestal, NY 13850
Ph# 607-729-0726
Fax# 607-729-1341

Mohan Dhillon MD,FAAAI,FRCP (c)
Alissa J. Strojny NP
website: www.BroomeAllergy.Com
email: AllergyAsthmaVestal@gmail.com

_____ has been scheduled for a Consultation (or) Consultation with Allergy Testing

On_____ at _____ am / pm. You can cancel or re-schedule your appointment by calling us at # 607-729-0726. Please leave a message on our answering machine if you call during non-office hours. 24 hour notice is required for cancellations. (Any canceled testing appointment will be rescheduled as a consult only.)

Your appointment will be rescheduled due to the following reasons:

- If you are late to the appointment
- Your paperwork is not received (1) day prior to the appointment
- No valid ID or Insurance information is presented
- Co-pay is not brought day of service
- You, or someone with you, wears perfume or cologne
- Our office is not a listed provider under your medical plan
- The insurance referral is not obtained from primary care prior to your appointment

MEDICAL INSURANCE: It is your own responsibility to know your medical plan benefits. Please call the customer service number on the insurance card to inquire about allergy testing / treatment or needing an actual insurance referral from your primary care. ***Our office does not accept workers comp or no fault insurance***

CANCELLATIONS / NO-SHOW POLICY: If you cancel your new patient evaluation two (2) times, you will not be scheduled again.

MINORS: need to be accompanied by an adult carrying a valid photo ID.

PAPERWORK: Your paperwork needs to be sent back to us at least (1) one day prior to your appointment by fax, email, drop off or regular mail. **PAPERWORK IS DOUBLE SIDED, PLEASE COMPLETE BOTH SIDES AND FILL OUT ALL FIELDS.**

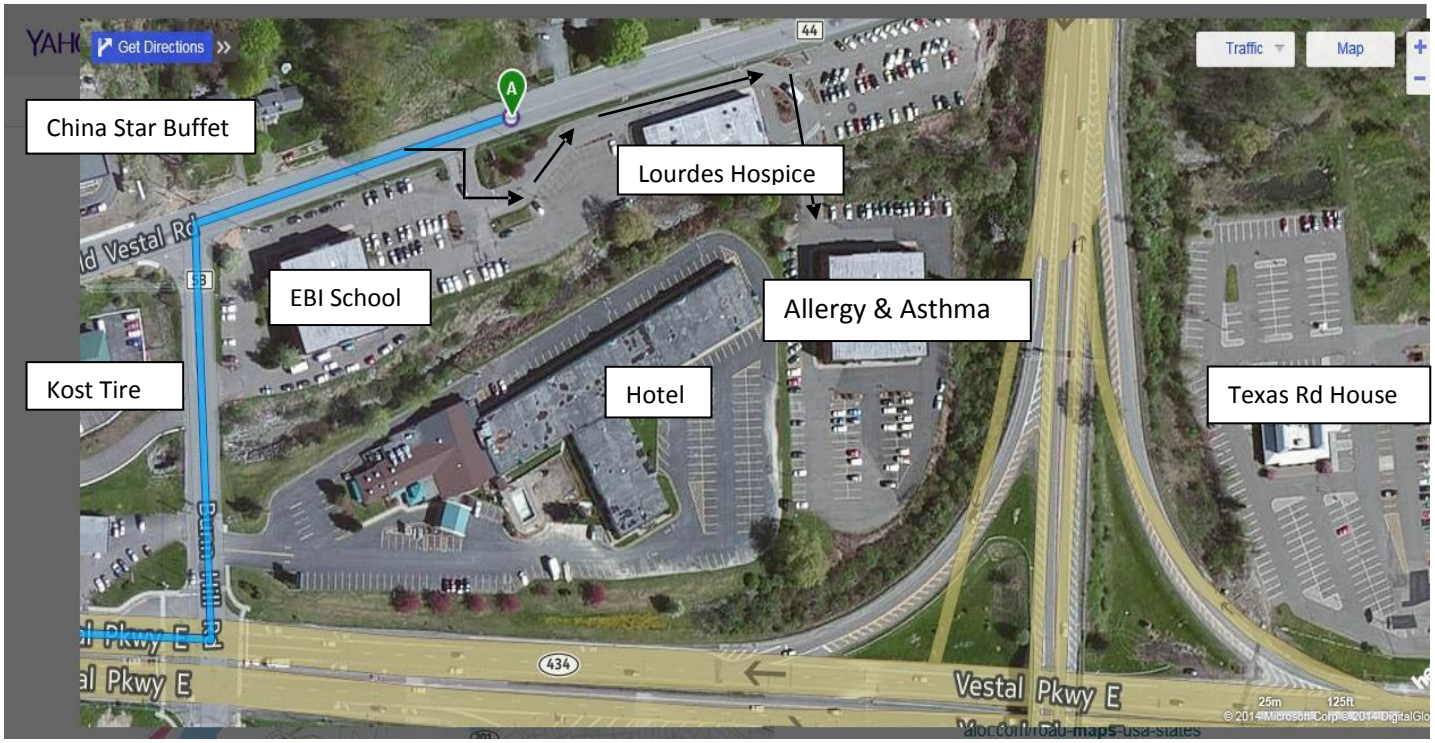
ALLERGY TESTING: DO NOT TAKE any medication (prescribed or over the counter) containing decongestants or antihistamines, five (5) days prior to your appointment. Call our nurse (prompt 3#) with any medical questions. If your allergy symptoms are too severe without taking medication, please call us to change your appointment to a consultation only.

HIVES, RASHES, FACIAL/THROAT SWELLING OR SKIN ISSUES: Please continue to take your medication as you cannot be tested with these symptoms. Skin testing or blood work will be scheduled if appropriate. Take photographs and bring them to your appointment or email them to "AllergyAsthmaVestal@gmail.com". These will be kept on your electronic medical record for a visual reference.

SELF PAY: Payments are due the day of your visit by cash or credit card only (Visa or Master Card). We do not accept personal checks for a new patient appointment.

Sincerely,

Allergy & Asthma Staff



<u>PLEASE NOTE:**</u> If using a GPS (TomTom, Garman, Phone Data Maps, etc) use the address: "4104 VESTAL RD", (**<u>Old</u> Vestal RD**will not come up in GPS systems.**)**

<u>Rt. 17/ Interstate # 86:</u> Use exit #70 South (exit just before or after Oakdale Mall depending on your direction) and take the #201 Bridge straight over into Vestal. Stay in the right lane. The first exit on the other side of the river is Old Vestal Rd. Take a right off the exit onto Old Vestal Rd. Vestal Executive Park is the first parking lot on the left before the intersection. After turning into the driveway, turn immediately left again and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Liberty Mutual)

<u>From 4 Corners Vestal:</u> Drive straight on Old Vestal Rd past Walmart/Sam's Club, Skate Estate, Staples Plaza until you come to the light at the Buffet Star (corner of Old Vestal Rd and Bunn Hill). Go straight through the light. Vestal Executive Park is the first parking lot on the right just past the EBI Building. After turning into the driveway, turn immediately left and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Liberty Mutual)

<u>From Binghamton up Vestal Parkway</u>: ** Due to construction ** Drive up Vestal Parkway, going past Binghamton University until you get to the intersection of Bunn Hill and the Parkway. Denny's restaurant will be on your left and the hotel on your right. Turn right onto Bunn Hill. Drive one block to next light at Old Vestal Rd, turn Right. We are the first driveway on Right. After turning into the driveway, turn immediately left and follow the driveway around the Lourdes Hospice building. This will bring you around to our building on the back left side. (Signs on the Building are: Allergy & Asthma, Dr. Newmark, Manpower, Liberty Mutual)

Allergy & Asthma Consultants PC

(Print) Patient Name:_____ DOB:_____

Welcome to Allergy & Asthma Consultants. We look forward to providing quality care to you, but before we can proceed, we need you to agree to the following terms: Please understand we expect monthly payments on account balances. This office accepts Visa, Master Card or health spending account cards. Checks are accepted with a valid photo ID, but returned checks are subject to additional service fees and could result in not accepting your personal checks after that.

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS: All co-payments are due to Allergy & Asthma Consultants on the day of service by the patient or accompanying adult. If you do not bring your coapy, you will be rescheduled. Patient agrees to pay what their insurance states is their responsibility. Office billing statements are mailed out monthly, only after the insurance carrier has processed your claim.

YOU, the patient and/or parents of a minor, are responsible to render payment due for treatment, should there be a remaining balance due to co-pays, co-insurance or high deductibles.

Claim payments denied by the insurance carrier for "non-coverage" or "no insurance referral on file", become the responsibility of the patient and you agree not to withhold payment from our office in the event of a dispute between you and your medical insurance carrier. Although we make every effort to obtain accurate information from you (or your referring medical office) prior to the appointment, verification of benefits is not a guarantee that the insurance carrier will pay a claim, or pay the amount estimated.

Patients are responsible for checking their own insurance benefits prior to treatment. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim. You are also responsible to notify us immediately if your insurance has changed for any reason. Insurance plans change yearly and you must be knowlegabe about your current benefit plan.

All accounts are required to have a monthly payment on balances. If a payment is not made after 90 days and there is no resolution, the account will be sent to our collections agecy and will result in discharge from the practice. Any discharged patient calling for future appointments will be referred to another office for treatment.

In the event that a patient does not have insurance and is paying by cash or credit card, we offer a discount off of our billable amounts.

I have read the above information and agree to all the terms and conditions contained therein.

Signature:_____ Date:_____

(parent / guardian signature for a minor)

(turn over)

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(**Please Print Clearly**)

Patient Name :First:_____. Last:_____. Date of Birth: _____/ _____ /_____Age: _____

Male ☐ Female ☐ Marital Status:(Circle one) Married / Single / Widowed / Divorced / Seperated / Partner

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

Home Ph#:_____ Cell#_____Work#_____

Employer Name:_____Address:_____

Emergency Contact:_____ Ph#_____ Relationship:_____

Is the patient a full time student? ☐ Yes ☐ No School attending:_____

Referring Doctor:_____ Address:_____ Ph#_____

Primary Care Doctor:_____ Address:_____Ph#_____

(Fill In ONLY If Patient Is A Minor)

Fathers Name:_____ Address:_____

DOB: _____Ph#:_____ Employer:_____

Mothers Name:_____ Address:_____

DOB: _____ Ph#:_____ Employer:_____

Insurance Information:

#1 Insurance:_____ ID#_____ Group#_____

Policy Holder Name:_____ Date of Birth: _____-_____-_____ Relationship_____

Employer and Address:_____

#2 Insurance:_____ ID#_____ Group#_____

Policy Holder Name:_____Date of Birth: _____-_____-_____ Relationship_____

Employer and Address:_____

Authorization for Assignment of Benefits and Information Release: I, the undersigned, authorize payment of medical benefits to Allergy & Asthma Consultants PC for any services and acknowledge that I am financially responsible for any unpaid balance. I further authorize Allergy & Asthma Consultants to release any medical information necessary to process any claims for insurance benefits covering my medical care.

SIGN HERE _____ Date:_____

(Or signature of parent / guardian if patient is a minor) Relationship:_____

If the patient is a minor (under 18 years of age) the patient must be accompanied by a parent or guardian.**(turn over)**

PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____/_____/_____

Pharmacy Name:_____ Location:_____

Drug Allergies	**Reaction**	**Allergies (environmental)**	**Reaction**
(example: Penicillin	example: Hives/rash)	(example: dogs/cats	Watery/itchy eyes & sneezing)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What symptoms are you being seen for at this appointment: _____

Patient Medical History & Conditions: _____

_____

_____

Surgical History & Dates: _____

_____

_____

Family Medical History (List by: mother, father, sister, brother) _____

_____

_____

_____

Current Medications: (please bring a list if needed)

Drug Name	**For what medical condition**	**Dose**	**Times per day**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(turn over)

Health Insurance Portability and Accountability Act (HIPAA)

Consent for disclosure of protected health information

By signing this form, you give consent for Allergy & Asthma Consultants PC to use and disclose your private and protected health information for the purpose of treatment and/or payment. Our Health Information Privacy information, which is located in our office waiting room, explains in detail how we use your health information. We encourage you to please pick up a copy if you are unfamiliar with this privacy act.

You can revoke any person given consent on this form by contacting our office directly by phone or written request.

Patient Name: _____ Date of Birth:_____

(please print)

I give the following listed individuals permission to speak directly to Allergy & Asthma Consultants about my medical care. I also understand I can revoke this permission at any time**. (Parents of a minor child and referring doctors are automatically included.)**

Name:_____ relationship:_____

Name:_____ relationship:_____

Name:_____ relationship:_____

SIGN HERE _____ Date:_____

(signature patient - or of a parent / guardian only if the patient is a minor or non-consenting adult)

(Relationship to patient if a minor child or non consenting adult):_____

(turn over)

ALLERGY HISTORY QUESTIONNAIRE

Patient Name: _____Today's Date:_____
DOB:_____ Age:_____

	Yes	No	Not Sure
Trouble with skin?			
Eczema	☐	☐	☐
Hives	☐	☐	☐
Ears?			
Popping	☐	☐	☐
Itching	☐	☐	☐
Hearing loss	☐	☐	☐
Fluid in ears	☐	☐	☐
Infection/Pain	☐	☐	☐
Throat?			
Frequently sore	☐	☐	☐
Post nasal drip	☐	☐	☐
Itchy throat/mouth	☐	☐	☐
Eyes?			
Redness	☐	☐	☐
Itching	☐	☐	☐
Tearing	☐	☐	☐
Puffiness	☐	☐	☐
Nose?			
Clear discharge	☐	☐	☐
Colored discharge	☐	☐	☐
Nasal itching	☐	☐	☐
Constant stuffy	☐	☐	☐
Periodic stuffy	☐	☐	☐
Sniffing	☐	☐	☐
Sneezing	☐	☐	☐
Mouth breathing	☐	☐	☐
Snoring	☐	☐	☐
Chest?			
Wheezing with colds?	☐	☐	☐
Wheezing when Exposed to dust, pollen, pets, etc?	☐	☐	☐
Wheeze after exercise?	☐	☐	☐
What kind of cough?			
Deep/productive	☐	☐	☐
Loose	☐	☐	☐
Constant	☐	☐	☐
Dry/tight	☐	☐	☐
Daytime	☐	☐	☐
Nighttime	☐	☐	☐
Are your symptoms :			
Mild	☐	☐	☐
Moderate	☐	☐	☐
Severe	☐	☐	☐
Most of the time	☐	☐	☐
Part of the time	☐	☐	☐
Rarely	☐	☐	☐
Interfering with normal activities	☐	☐	☐
Preventing normal activities?	☐	☐	☐

Which of the following do you think cause your symptoms or make them worse?	Yes	No	Not Sure
Indoors	☐	☐	☐
Outdoors	☐	☐	☐
At home	☐	☐	☐
At work	☐	☐	☐
Morning	☐	☐	☐
Afternoon	☐	☐	☐
Nighttime	☐	☐	☐
Weather changes	☐	☐	☐
Wet weather	☐	☐	☐
Dry weather	☐	☐	☐
Windy	☐	☐	☐
Hot days	☐	☐	☐
Cold days	☐	☐	☐
Air conditioning	☐	☐	☐
In barns	☐	☐	☐
Dampness	☐	☐	☐
Hay	☐	☐	☐
Mowing lawn	☐	☐	☐
Dust	☐	☐	☐
Animals	☐	☐	☐
Cooking odors	☐	☐	☐
Smoke	☐	☐	☐
Soap	☐	☐	☐
Insecticides	☐	☐	☐
Paint fumes	☐	☐	☐
Perfumes	☐	☐	☐
Cosmetics	☐	☐	☐
Hair solon products/perm/color/straightener	☐	☐	☐
Newspaper	☐	☐	☐
Wool	☐	☐	☐
Road dust	☐	☐	☐
Milk or milk Products	☐	☐	☐
Eggs	☐	☐	☐
Wheat products	☐	☐	☐
Nuts/beans/seeds	☐	☐	☐
Chocolate	☐	☐	☐
Fish	☐	☐	☐
Chicken	☐	☐	☐
Red meat	☐	☐	☐
Pork	☐	☐	☐
Fruit	☐	☐	☐
Vegetables	☐	☐	☐
Cheese,mushroom	☐	☐	☐
Alcoholic drinks	☐	☐	☐
Beer	☐	☐	☐
Wine	☐	☐	☐
Aspirin	☐	☐	☐

Other:_____

_____

_____

Do certain chemicals make symptoms worse?: Please list:

_____

_____

_____

Do certain drugs make symptoms worse?
Please list:

_____

_____

_____

During what months do you have symptoms? Check all that apply.

All year round	☐
January	☐
February	☐
March	☐
April	☐
May	☐
June	☐
July	☐
August	☐
September	☐
October	☐
November	☐
December	☐

What symptoms bother you most?

_____

_____

When or at what age did your symptoms start?

_____

Do you use medication regularly for allergy symptoms? Yes ☐ No ☐

If yes, what medication(s):

_____

_____

_____

Does medication help?
Yes ☐ No ☐ sometimes ☐

(Turn over)

Do you take any of these medicines daily or frequently?

	Daily	Sometimes	No
Aspirin	☐	☐	☐
Cortisone	☐	☐	☐
Laxatives	☐	☐	☐
Sedatives	☐	☐	☐
Antihistamines	☐	☐	☐
Decongestants	☐	☐	☐
Birth control pills	☐	☐	☐
Vitamins	☐	☐	☐
Ointments	☐	☐	☐
Nose drops/sprays	☐	☐	☐
Hormones	☐	☐	☐

Do any family members have allergies?
Yes ☐ No ☐ Not sure ☐

If yes, who? And do you know what they are allergic to?

_____

_____

_____

_____

Is there anything about your allergy problems that you think we should know?

_____

_____

_____

_____

Are there smokers in the home? (this inclused smoking outside)
Yes ☐ No ☐

Does the patient smoke? Yes ☐ No ☐

If yes, Cigarettes #_____ per day

Pipe Yes ☐ No ☐

Cigar Yes ☐ No ☐

E-Cigaretes Yes ☐ No ☐

Years smoked _____

Date stopped smoking_____

Do you have hobbies or play sports?: Please list:

_____

_____

_____

Have you had pets in the home previously?
Yes ☐ No ☐

Are there animals in the home currently?
Yes ☐ No ☐

If **yes** to either, what kind and how many:

_____

_____

_____

Do you live in a:	**Yes**	**No**
House	☐	☐
Apartment	☐	☐
In the city	☐	☐
In the suburbs	☐	☐
Is your house/apt new?	☐	☐
3-10 years old	☐	☐
11-25 years old	☐	☐
26 years or older	☐	☐

Have you had any of the following?		
High blood pressure	☐	☐
Migraine headaches	☐	☐
Regular daily headaches	☐	☐
Skin disease	☐	☐
Heart disease	☐	☐
Sinus disease	☐	☐
Stomach disease	☐	☐
Asthma	☐	☐
Nasal polyps	☐	☐
Nasal surgery	☐	☐
Broken nose	☐	☐
Emphysema	☐	☐
(Over active) thyroid	☐	☐
(Under active) thyroid	☐	☐
Bronchitis	☐	☐
Hay fever	☐	☐
Deviated septum	☐	☐
Hormonal difficulty	☐	☐
Hives	☐	☐

Known food allergies, if yes please list with allergic reaction:

_____

_____

_____

Please describe your place of employment and occupation, or where you go to school:

_____

_____

_____

Are there any materials used at work or school that you think might be bothering you? If yes please describe:

_____

_____

_____

Are your symptoms better at:	
Work	☐
Home	☐
School	☐
The same at both	☐
Not sure	☐

Do you sleep with a pillow?	
Is it Dacron	☐
Foam rubber	☐
Feather	☐
Synthetic stuffing	☐
Other:_____	
Not sure	☐

Is your mattress:	
Feather	☐
Foam rubber	☐
Cotton	☐
Other_____	☐
Not sure	☐

	Yes	**No**
Do you use a humidifier	☐	☐
Air conditioner	☐	☐
At work	☐	☐
At home	☐	☐
In bedroom	☐	☐
Central air	☐	☐

Is your heating system	
Oil	☐
Gas	☐
Electric	☐
Coal	☐
Wood stove	☐
Other:_____	

Is your heat delivered by:	
Blower	☐
Radiators	☐
Electric panels	☐
Other: _____	

HealthlinkNY Health Information Exchange

LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

ORGANIZATION: **ALLERGY & ASTHMA CONSULTANTS PC**

I understand that I can choose whether to allow the Provider Organization or Health Plan named above to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I receive health care. HealthlinkNY is a not-for-profit organization that electronically shares information about people's health and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit the HealthlinkNY website at www.healthlinkny.com.

Your choice will not affect your ability to receive medical care or obtain health insurance coverage. Your choice to give or deny consent may not be used as the basis for denial of health services. The choice you make on this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

Before making your decision, please carefully read the Consent Form Information Sheet about how your information is used.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form. This form must be filled out completely to be valid.

Please choose only one of the following two options:

☐ **I GIVE CONSENT** for the Provider Organization or Health Plan named above to access ALL of my Electronic health information through HealthlinkNY in connection with providing me health care Services, including emergency care.

☐ **I DENY CONSENT** for the Provider Organization or Health Plan named above to access my electronic Health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Provider Organizations and Health Plans participating in HealthlinkNY, you may do so by visiting WWW.HealthLinkNY.com or calling 844-840-0050.

_____ _____ _____ / _____ / _____

Printed Frist Name of Patient | Printed Last Name of Patient | Patient Date of Birth MM / DD / YYYY

_____ _____ / _____ / _____

Signature of Patient | Date of Signature

---------- **This Section below is to be completed by the Patient's Legal Representative (if applicable)**----------

_____ _____ _____

Printed First Name of Legal Representative | Printed Last Neame of Legal Representative | Relationship of Legal Representative

_____ _____

Legal Representative Signature | Date of Legal Representative Signature