nyasc Allergy & Sinus Centers
www.NYAllergy.com
Phone 212.686.6321 Fax 212.686.6329

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Martin Ronan, PA-C
Kyle Colquhoun, PA-C
Yelena Solovyeva, PA-C

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Sex: ❒ Male ❒ Female

Home Address: _____ Email: _____

Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Ethnicity: Do you consider yourself Hispanic/Latino? ❒ Yes ❒ No

Race: ❒ American Indian/Alaska Native ❒ Asian ❒ Black/African American
❒ Native Hawaiian/Other Pacific Islander ❒ White ❒ Other Race

Patient is: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Student ❒ Child

Preferred Language: ❒ English ❒ Spanish ❒ Other _____

Preferred Contact: ❒ Home Phone ❒ Cell Phone ❒ Email ❒ Patient Portal ❒ Other _____

HOW DID YOU HEAR ABOUT NYASC?

❒ ZocDoc (link from our website) ❒ ZocDoc (directly) ❒ NYAllergy.com ❒ AdvancedAllergyNY.com ❒ Family/Friend
❒ Doctor ❒ Health Center ❒ Yahoo ❒ Google ❒ Yelp ❒ Work ❒ Radio ❒ TV ❒ Metro NY ❒ NY Post

Name of person, doctor, or company: _____

YOUR OTHER DOCTORS

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

ENT (Ear Nose Throat): _____ Phone: _____

INSURANCE SUBSCRIBER / GUARANTOR (if insurance is not in patient's name)

Relationship of Patient to the Subscriber: ❒ Self ❒ Child ❒ Spouse ❒ Other _____

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

PREFERRED PHARMACY

Company/Pharmacy: _____

Address/Cross Streets: _____ Phone Number: _____

City: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

I, _____ (the patient), acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature of Patient or Responsible Party: _____

YOUR RIGHTS AND YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. **FOR ALL EMERGENCIES, CONTACT 911.**
2. Email is an inherently insecure form of communication. Do not email any sensitive information. In case of an emergency, do not send an email to our staff, CALL 911. Please be aware that some email may go unanswered because the addressee may be out of the office or busy seeing patients. If you do not get a reply within 3 hours, we recommend that you call us to follow up.
3. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to NY Allergy and Sinus Group, 116 East 36th Street, Lower Level, NY, NY 10016 (or fax 212-686-6329).
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to NY Allergy and Sinus Group, 116 East 36th Street, Lower Level, NY, NY 10016 (or fax 212-686-6329). You must provide us with a reason that supports your request for amendment.
6. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact NY Allergy and Sinus Group, 116 East 36th Street, Lower Level, NY, NY 10016.

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7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact NY Allergy and Sinus Group, 116 East 36th Street, Lower Level, NY, NY 10016. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by NY Allergy and Sinus Group.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due NY Allergy and Sinus Group agree to pay all cost of collections including collection agency fees. I understand there is a $25.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Shield and/or any other agency involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to NY Allergy and Sinus Group. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to NY Allergy and Sinus Group for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by NY Allergy and Sinus Group.
7. I authorize a copy of my NY Allergy and Sinus Group medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

I hereby authorize direct payment to Dr. Morris Nejat (doctor and/or any service supplier) of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, including collection fees, court costs, attorney fees, and prejudgment interest at the highest amounts allowed under the law, whether or not paid by insurance, and for all services rendered on my behalf or my dependents'. I authorize the doctor and/or any service supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party: _____

REFERRAL RESPONSIBILITY

This is to advise you that it is your responsibility, as a patient, to obtain a referral from your primary Care Physician for services rendered. This referral must be dated prior to the time of service. It is also your responsibility to keep track and make a copy of your referrals to be sure that the visits or length of time of the referrals do not run out.

If a referral is not obtained, and you are required to have one, you will be responsible for the payment to the doctor.

Signature of Patient or Responsible Party: _____

Date: _____ Witness: _____

Form Updated 12/17/2015

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Patient Questionnaire

Patient Name _____ Date of Birth _____

- Reason for today's visit: _____
  (Allergies, Hives, Itching, Asthma, etc.)

- Where does the problem occur?
  - o Skin
  - o Eyes
  - o Nose
  - o Throat
  - o Sinus
  - o Chest
  - o Head
  - o Ears
  - o Other: _____

- How long has this been happening?
  - o ___ Years
  - o ___ Months
  - o ___ Weeks
  - o ___ Days
  - o ___ Hours
  - o My whole life
  - o Since childhood

- When does this occur?
  - o Morning
  - o Evening
  - o Always
  - o Seasonally
  - o Spring
  - o Summer
  - o Fall
  - o Winter

- What triggers the problem? _____

- Associated signs and symptoms: _____

- Are you taking any medications?
  - o Yes (please specify): _____
  - o No
- Have you gotten a flu shot this year?
  - o Yes
  - o No
- Have you had any surgeries?
  - o Yes: _____ (Year and Reason)
  - o No
- Any hospitalizations?
  - o Yes: _____ (Year and Reason)
  - o No
- Any emergency room visits?
  - o Yes: _____ (Year and Reason)
  - o No

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- My family has a history of (which family member; p - parent, s - sibling or c -child):
  - o Asthma ❒p ❒s ❒c
  - o contact dermatitis ❒p ❒s ❒c
  - o eczema ❒p ❒s ❒c
  - o food allergy ❒p ❒s ❒c
  - o hives ❒p ❒s ❒c
  - o insect allergy ❒p ❒s ❒c
  - o latex allergy ❒p ❒s ❒c
  - o medication allergy ❒p ❒s ❒c
  - o respiratory allergies ❒p ❒s ❒c
  - o thyroid disorder ❒p ❒s ❒c
  - o acne ❒p ❒s ❒c
  - o anemia ❒p ❒s ❒c
  - o autoimmune disease ❒p ❒s ❒c
  - o cancer ❒p ❒s ❒c
  - o diabetes ❒p ❒s ❒c
  - o heartburn ❒p ❒s ❒c
  - o high blood pressure ❒p ❒s ❒c
  - o high cholesterol ❒p ❒s ❒c
  - o irritable bowel syndrome (IBS) ❒p ❒s ❒c
  - o other ❒p ❒s ❒c _____

- I have a history of:
  - o asthma
  - o contact dermatitis
  - o eczema
  - o food allergy
  - o hives
  - o insect allergy
  - o latex allergy
  - o medication allergy
  - o respiratory allergies
  - o thyroid disorder
  - o acne
  - o anemia
  - o autoimmune disease
  - o cancer
  - o diabetes
  - o heartburn
  - o high blood pressure
  - o high cholesterol
  - o irritable bowel syndrome (IBS)
  - o other _____

- I have a history of allergic reactions to: (please indicate what food/medication/etc. caused the reaction, and what type of reaction you experienced)
  - o Food _____
  - o Medication _____
  - o Latex _____
  - o Insect stings _____

- Do you have an Epipen?
  - o Yes
  - o No
  - o Yes, but it is expired.
  - o I used to.

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- Smoking Status?
  - o Never Smoker
  - o Current Every Day
  - o Heavy Tobacco Smoker
  - o Former Smoker
  - o Current Some Day
  - o Light Tobacco
    - How many cigarettes per day? _____
    - If you quit, when? _____
- Tobacco Use Screening
  - o History of Use
  - o Used Tobacco In Last 30 Days
  - o Used Smokeless Tobacco In Last 30 Days
- Are you regularly exposed to second-hand smoke?
  - o no
  - o yes, how much? how often? _____
- Do you drink alcohol?
  - o no
  - o yes, how many drinks per week? _____
- What is your occupation?_____
- I live in a:
  - o house
  - o apartment
- I have lived there for:
  - o ____ years
  - o ____ months
- The flooring in my living room is:
  - o wood
  - o tile
  - o area rugs
  - o carpet
- The flooring in my bedroom is:
  - o wood
  - o tile
  - o area rugs
  - o carpet
- Does your home have mold damage?
  - o no
  - o yes, where? _____
- My basement has:
  - o carpeting
  - o mold damage
  - o a musty smell
  - o no apparent mold or damage
  - o water damage
  - o I don't have a basement.
- My home is heated by:
  - o central forced air
  - o radiator
- My home is cooled by:
  - o central forced air
  - o no a/c
  - o window units

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- I have this type of humidifier:
  - o central
  - o separate unit
  - o no humidifier
- I sleep on:
  - o mattress & box spring
  - o mattress only
  - o futon mattress
  - o water bed
- My mattress is:
  - o ____ years old
  - o ____ months old
- I use a mattress cover (for allergies or dust mites):
  - o yes
  - o no
- My pillows are:
  - o feather
  - o non-feather
- I use pillow covers (for allergies or dust mites):
  - o yes
  - o no
- My comforter is:
  - o feather
  - o non-feather
- I use a duvet cover (for allergies or dust mites):
  - o yes
  - o no
- My building has a problem with:
  - o rats/mice
  - o cockroaches
  - o none
- I have these pets:
  - o dog
  - o cat
  - o other: _____
  - o bird
  - o none
- I used to have these pets:
  - o dog
  - o cat
  - o other: _____
  - o bird
  - o none
- My pets are allowed in my bedroom:
  - o no
  - o yes, which ones? _____
- I visit family or friends that have pets:
  - o no
  - o yes, which pets? _____
    how many days per month? _____