NEAAI

Northeast Allergy, Asthma & Immunology

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Thank you for choosing Northeast Allergy Asthma & Immunology

Patient: _____ Date of birth: _____

Date of Appointment:

_____

The appointment is scheduled with:

_____

Location: _____

Welcome! Here is your New Patient Packet

Enclosed you will find information and instructions for your first visit with us. Along with:

HIPAA Consent to treat and bill your insurance form

HIPAA Omnibus Notice of Privacy Practices

New Patient Form

Patient Demographics Form

Please complete the forms and bring them with you to your appointment.

Important information regarding appointment

Missed Appointment Fees: To ensure appointment availability for our patients, we charge a "no show" fee for missed appointments that are not canceled at least 24 hours in advance. The charge is $25 for follow up appointments and $50 for new patient appointments. Please make every effort to keep your appointment for the time and date it's made. Thank you.

Insurance Plan Deductibles: Does your insurance plan have a deductible? Please be advised our office charges $150 towards your annual deductible. This is only done annually and is credited towards your deductible. Any remaining balance will be billed after your insurance is processed. We appreciate your co-payment at the time of your visit. Thank you.

Antihistamines and decongestants can interfere with skin testing by blocking the allergic response. In order for us to give you accurate test results please stop all prescription and over the counter antihistamines and decongestants **PRIOR** to your appointment. These medications include:

- cough and cold remedies
- motion sickness medications
- sleep aids

Some antihistamines are longer acting. These must be stopped for **7 days before** allergy testing:

- Cetirizine/Zyrtec
- Cortisone cream to the arms or back
- Desloratadine/Clarinex
- Doxepin/Sinequan
- Fexofenadine/Allegra
- Loratadine/Claritin/Alavert/or generic
- Levocetirizine/Xyzal

Stop **three days before** the test:

- Azelastine HCL/Astelin/Astepro
- Hydroxyzine/Atarax/Vistaril
- Olopatadine/Patanase
- Sudafed
- Tussinex
- Actifed
- Advil Allergy/Sinus
- Chlorpheniramine/Chlortrimetron
- Cyproheptadine/Periactin
- Contac
- DayQuil
- Deconamine
- Dimetapp
- Diphenhydramine/Benadryl
- Drixoral
- Duravent DA

- Dura-tap
- Zantac/Rantitidine

All other cough/cold medicines should be stopped two days before the test.

Stop **one day before** the test:

- Amitriptyline/Elavil
- Desipramine/Norpramin
- Nortriptyline/Pamelor
- Imipramine/Tofranil
- Trazodone/Desyril

If you are on any beta-blockers (Tenormin/Atenolol, Lopressor/Toprol-XL/Metoprolol, Corgard/Nadolol, Trandate/Labetalol, Inderal/Propranolol, or Normodyne), please contact our office prior to your appointment for further instruction.

DO NOT STOP ANY ASTHMA MEDICATIONS or nasal steroids. Do not stop Singulair. Do not stop any inhalers. Do not stop any blood pressure medications or eye drops, unless this has been arranged with your primary care physician in advance.

Most drugs do not interfere with testing, but make certain that your physician and nurse know about every drug you are taking (bring a list or the drugs if necessary).

Please do not wear perfumes or aftershaves on the day of your appointment as it may be irritating to another patient with respiratory symptoms. Please do not bring nut containing foods into the office. Please allow a minimum of 2 hours for this appointment.

Northeast Allergy, Asthma & Immunology

Patient Demographics:

Last Name: _____ First Name:_____ Middle Initial: ____

Date of Birth: ___/___/___ Sex: ____ Email:_____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Primary Contact #: (____)_____-_____ Secondary contact #: (____)_____-_____

Preferred form of contact for appointment reminders: ☐ Home ☐ Cell ☐ Email ☐ Text

Pharmacy:

Name & Address: _____

City: _____ State: ____ Zip code: _____ Phone: _____

PLEASE CIRCLE ONE IN EACH BOX: **Race:**	**Ethnicity:**	**Language:**
Caucasian/White	Hispanic/Latino	English
Hispanic	Non-Hispanic/ Latino	Spanish
African American/Black	Other: _____	Russian
Asian		Indian
Other: _____		Other: _____

Primary Emergency Contact Name: _____

Phone Number: (____)_____-_____ Relationship: _____ Legal Guardian? Y / N

Secondary Emergency Contact Name: _____

Phone Number: (____)_____-_____ Relationship: _____ Legal Guardian? Y / N

Acknowledgement of Patient Privacy Rights (HIPAA)

I, _____ (print name) hereby acknowledge that I was offered a copy of NEAAI Joint Notice of Information Practices. I understand that this notice describes how the practice uses and discloses my medical and billing information as well as description of my rights and how I may obtain additional information.

I would like a copy _____ I would not like a copy _____

_____ _____ _____

Signature of Patient/Parent/ Legal Representative Date Relationship to patient

Patient Name: _____ DOB: _____

(OPTIONAL) In order to remain compliant with medical information laws, written authorization must be provided if you wish us to share protected medical information with anyone other than a minor's legal guardian. Consent must also be provided by a patient once they reach the age of 18 years old if they wish to authorize any other adult to contact our office on their behalf or request medical information.

_____	_____	_____
(*Name)*	*(Relationship to patient)*	*(Phone number)*
_____	_____	_____
(*Name)*	*(Relationship to patient)*	*(Phone number)*

If you wish to limit access to your protected health information, please identify the medical information that you do not wish to be shared: _____

By signing below you hereby give permission to Northeast Allergy, Asthma, & Immunology (NEAAI) to relay such information to the individuals listed here. *Please note:* This authorization **does not** grant permission to the individual(s) listed above to act on your behalf as your Health Care Proxy.

_____ _____

(Signature) *(Date)*

*(This consent form is considered **valid for three years** from the date of signature **unless revoked in writing or a new consent form is submitted.** This consent form now supersedes all previous consent forms and any individuals designated on those forms. Please inform the individual(s) listed above that they may be required to provide identification when requesting information.*

Financial Policy: NEAAI requests prompt payment of all outstanding financial balances. If you have any questions regarding your bill or your insurance company's *Explanation of Benefits (EOB)* statements, please call our office. We recognize that some of our patients may experience financial difficulties at times, so please let us know if we can assist you with creating a comfortable payment plan that will accommodate your family's budget. Unfortunately, failure to comply with this policy may result in discharge from the practice.

"No-Show" Policy: NEAAI defines a "no-show" appointment as any scheduled appointment in which the patient (1) does not arrive for appointment and does not call the office (2) Cancels an appointment less than 24 hour before the scheduled appointment time with an inappropriate reason (3) Arrives late to their appointment without calling ahead and is consequently unable to be seen. *After continued infringements of the NEAAI "no-show" policy, we reserve our right to discharge the patient from our practice, as we may no longer feel comfortable managing the care of this patient who chooses to continually jeopardize his or her own healthcare, or that of their children.*

I hereby authorize medical treatment for myself and the release of any medical information necessary to process all insurance claims to my insurance carrier(s) and the payment of such directly to Northeast Allergy, Asthma, & Immunology (NEAAI). I also understand and acknowledge that any charges for medical care provided that are either not covered by my medical insurance or not reimbursed directly to NEAAI, including all plan deductibles, are my personal financial responsibility, I hereby acknowledge that all fees, costs, etc. (including legal fees and court costs) associated with the collection of any unpaid fees are also my personal responsibility, I hereby acknowledge that the details (what "covered charges" are; what the annual and per visit deductible costs are, etc.) of the medical insurance coverage that I have is solely my responsibility to understand prior to any medical care provided to me by NEAAI; as well as all tests, lab work and other related medical activity recommended to me by NEAAI. I also hereby authorize the staff of NEAAI to view my prescription history through external resources.

_____	_____	_____
Signature of patient/parent/ legal representative	Date	Relationship to patient

Northeast Allergy, Asthma & Immunology
New patient Information

Patient Name: _____
Date of Birth: _____ **Appointment Date:** _____
Address: _____
_____
Parent/Guardian: _____
Parent/Guardian: _____
Parent address (if different):
_____
_____
Home Phone: _____
Cell Phone Patient or Parent: _____
Pharmacy name and address: _____
_____
Referring doctor name: _____
Doctor's address: _____
_____
Reason for visit today (Why are you here?):
_____
_____
_____
_____
_____

Review of Systems:
Circle any of the following problems that the *patient* has (not family members): **PLEASE CIRCLE NONE if applicable:**
General: fevers, fatigue, weight loss, feeling cold or hot when others are comfortable, none
Eyes: Itchy, red eyes, cataracts, eye infections, none
Ears: Recurrent ear infections, hearing loss, none
Nose: Hay fever, sinus infections, chronic sinus pressure, stuffy nose, inability to smell, itchy nose, runny nose, none
Throat: Recurrent strep throat, sore throat, post nasal drip, tonsillitis, none
Chest: Chronic cough, wheeze, recurrent pneumonia, COPD, asthma, chest pain, none
Heart: Abnormal rhythm, palpitations, high blood pressure, heart disease, coronary artery disease, none
Gastrointestinal: Stomach pain, acid reflux, heartburn, GERD, ulcers, vomiting, diarrhea, constipation, blood in stool, none
Skin: Eczema, hives, swelling, psoriasis, other rashes, none
Endocrine: Diabetes, growth problems, thyroid problem, none
Genitourinary: Recurrent urinary tract infections, renal disease, prostate problems, none
Musculoskeletal: Arthritis, swollen joints, Lyme disease, none
Neurologic: ADHD, Developmental delay, seizures, migraine, none
Lymphatics: Swollen lymph nodes, abnormal lymph nodes, none
Hematologic: Anemia, Sickle cell, none
Psychiatric: Anxiety, depression, other, none

Hospitalizations: _____
_____
_____
_____
Surgeries: _____
_____
_____
Allergic reactions to Medications (ie. Penicillin allergy)
_____
_____
Daily Medications: _____
_____
_____
_____
_____
_____
Medications taken as needed:
_____
_____
_____
Medications that did not work for your problem in the past:
_____
_____
_____
_____

Family History:
Please circle any of the following if the patient's parents, siblings, grandparents, or cousins have them:

Asthma	Seasonal allergies	Lupus
Eczema	Food allergies	Hives
Thyroid disease	Indoor allergies	COPD
Heart disease	Immune defect	Other:

Home Environment:
Do you live in a house or apartment (please circle)?
Are there any pets? Yes/No. If so what?
_____
What kind of heating do you have (please circle)?
Forced hot air (comes in through vents), base board heating, radiators, wood burning stove.
Air conditioning (please circle)? Central window units, none
Any problems with (circle): Mice, roaches, mold
In the patient's bedroom are there: Carpeting: Yes/No;
Stuffed toys on the bed: Yes/No; Feather Bedding: Yes/No
Does anyone smoke at home? _____
For adult patients: Have you ever smoked: Yes/No
If so how much? _____ packs per day, _____years
Quit date: _____ Drink Alcohol: Yes/No

Other information you want us to know:
_____
_____
_____