Joel H. Selter, M.D.
Raizy Klahr, PA-C ● Jessica Valle, PA-C

222 Route 59 Suite 109, Suffern, NY 10901
Phone 845.357.7277
contact@aacrockland.com

505 Route 208 Suite 21, Monroe, NY 10950
Fax 845.357.5516
www.aacrockland.com

Thank you for selecting Allergy & Asthma Care. Your consultation is scheduled for __________ at ____am/pm at the Suffern/Monroe office.

PLEASE ARRIVE 15 MINUTES BEFORE APPOINTMENT TIME

Please read the instructions and complete the attached forms. If you are unclear about the instructions, please call us at 845-357-7277.

You *must* bring all COMPLETED AND SIGNED FORMS, INSURANCE CARDS, VALID PHOTO I.D., AND REFERRALS with you to the visit.

If you do not bring your insurance information, you will be required to sign a payment responsibility waiver.

Please provide 24-hours' notice if you need to cancel your consultation appointment.

We look forward to seeing you.

DIRECTIONS TO THE MONROE OFFICE:

Take the New York State Thruway North/I87N. Merge onto NY-17 West via EXIT 16/RT 17. Go to EXIT 130 Washingtonville. Bear left off exit. The building will be in front of you.

505 Route 208
Suite 21
Monroe, NY 10950
845-782-0882

DIRECTIONS TO THE SUFFERN OFFICE:

Take the New York State Thruway to EXIT 14B. If heading NORTH, make a LEFT off the exit. If heading SOUTH, make a RIGHT off the exit. Go to intersection ROUTE 59 (you will see the diner on the right). Make a LEFT (EAST). Go about 200 yards. Building will be on the LEFT side #222. Make a LEFT into the parking lot. Go to the BACK of the building. When facing the doors, go through the doors on the RIGHT.

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PATIENT INSTRUCTION SHEET FOR AEROALLERGEN & FOOD ALLERGY SKIN TESTING

You may be skin tested to important local airborne allergens and/or foods allergens. These may include trees, grasses, and weed pollens, molds, dust mites, and danders (and/or foods such as milk, egg, peanut and others). The skin testing generally takes approximately 60 minutes. Puncture tests will be performed on your lower arm or back and intradermal tests on your upper arms. If you have a specific allergic sensitivity to one of the allergens, a red, raised itchy hive (caused by histamine release into the skin) will appear on your skin within 15-20 minutes. These positive reactions will gradually disappear over a period of 30-60 minutes, and typically, no treatment is necessary. Local swelling at a test site (which itches occasionally) can begin 4 to 8 hours after the skin tests are applied. These reactions are not serious and will disappear over the next week. They should be measured and reported to your physician at your next visit. If they are bothersome, please call the office for instructions on local treatment.

DO NOT USE:

1. Antihistamines should not be used 2-7 days prior to the scheduled skin testing. Refer to the table on the next page for specific medication and withholding time. These include cold tablets, sinus tablets, hay fever medications, or treatments for itchy skin. Some of the names of these drugs include Actifed, Drixoral, Claritin, Alavert, Allegra, Dimetapp, Benadryl, Tavist, Trinalin, Periactin, Tylenol PM, Tylenol PM Allergy Sinus, Xyzal or Zyrtec. Medications with the" PM" designation usually contain antihistamines. If you have any questions, whether or not you are using an antihistamine, please ask the nurse or doctor.
2. Medications such as over-the-counter sleeping medicines (e.g., Nytol) and other prescribed drugs such as amitryptyline hydrochloride (Elavil), doxepin (Sinequan) and imipramine (tofranil) have antihistaminic activity and should be discontinued at least **TWO weeks prior** to skin tests. Please also discuss with the doctor who prescribed these medications, if it is appropriate for you to discontinue the medications temporarily.
3. Patients on Astelin, Astepro, Patanase or Dymsta nasal spray should not use this medication for 48 hours prior to the tests.

YOU MAY USE:

1. Continue on your intranasal allergy sprays such as Flonase (Flucticasone), Nasacort, Rhinocort, Nasonex, Nasalcrom, Nasarel, Veramyst or Omnaris. Entex or Sudafed may also be used temporarily, but not on the day of testing. All asthma medications, including Singulair, Zyflo and Accolate, should be continued.
2. Most drugs do not interfere with skin testing, but make certain that your physician or nurse knows about every drug you are taking.

After skin testing, you will meet with the doctor (either the same day or possibly another day) who will make further recommendations regarding your treatment.

NOTE: If you are taking blood pressure/heart medication—beta blocker—such as Tenormin, Atenolol or Corgard, etc., please discuss this with the physician prior to testing—as we may need to taper these medications.

NOTE: We request that you do not bring small children with you to your skin-testing appointment unless they are accompanied by another adult who can sit in the waiting room. Please do not cancel your appointment since the time set aside for your skin tests is exclusively yours. If for any reason you need to change your appointment, please give us at least 48 hours' notice. Due to the length of time for skin testing, a last minute change results in loss of valuable time that another patient might have utilized. We thank you for your cooperation.

EFFECTS OF ANTIHISTAMINES ON ALLERGY SKIN TESTS

Antihistamines taken orally can block responses to immediate-type allergy skin tests. Below is a list of some commonly used antihistamines and the approximate amount of time that these medications must be withheld prior to immediate hypersensitivity allergy skin tests:

MEDICATIONS:	AMOUNT OF TIME:
1. Benadryl/Tylenol Allergy & Sinus or PM	3 days
2. Chlortrimeton (chlorpheniramine Short-act) 4mg	3 days
3. Chlortrimeton 12 ms (12 hour)	3-4 days
4. Tavist (clemastine)	4 days
5. Claritin/Claritin D-24 or D-12/Redi-tabs (loratadine)/Alavert	7 days
6. Clarinex 5md, Clarinex D	7 days
7. Allegra (fexofenadine) 60 mg/Allegra D-12 hour	5 days
8. Allegra (fecofenadine) 180 mg	5 days
9. Zyrtec (cetirizine)	5 days
10. Xyzal (levocetirizine)	7 days
11. Astelin, Astepro, Patanase or Dymista Nasal Spray	2 days
12. Atarax/Vistaril (hydroxyzine)	7 days
13. Periactin (cyproheptadine)	5 days
14. Tricyclic antidepressants (Elavil, Amitryptiline, Nortriptyline)	10-14 days
15. Elestat, Patanol, Optivar or Zaditor eye drops	1 day

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THIS SHEET (FRONT AND BACK) must be completed PRIOR to your visit.

Name:____________________________________ D.O.B._________________

The reason for your visit and history of your symptoms:
____
____
____

Symptoms occur: □All Year □Spring □Summer □Autumn □Winter □Other______

What makes your symptoms worse?
____
____

What makes your symptoms better?
____
____

What medications have you tried for these symptoms? Do they help?
____
____

Have you seen an allergist before? □NO □YES Who?_____________ Date:______

Please list all medications that you are currently taking. **Include** vitamins, herbal supplements and over-the-counter preparations:
____
____

Name, address and phone number of your primary care physician (gynecologist, if applicable):
____
____

Are you allergic to any medications/foods? □NO □YES If yes, please list:____

Name:____________________________________ D.O.B._________________

PLEASE CHECK ALL THAT ARE APPLICABLE:

Does anyone in your household smoke? □NO □YES

Have you ever smoked? □NO □YES

If yes, age you started: _______ packs per day: ________age you quit: _____________

Do you live in a: □ House □ Condo □ Townhouse □Apartment

Heating system: □NO □YES Humidifier: □NO □YES

Dehumidifier: □NO □YES Air cleaner: □NO □YES

Is there a basement? □NO □YES

Animal exposure: □CAT □DOG □BIRD □OTHER:_______________

Flooring in bedroom: □wall-to-wall □area rugs □hardwood floor □tile □vinyl

Flooring in living areas: □wall-to-wall □area rugs □hardwood floor □tile □vinyl

Upholstered furniture: □ Bedroom □Living areas

Type of mattress: □ Regular □ Water □ Air Mattress Age of Mattress:_______________

Pillow: □ Feather □ Non-Feather Comforter: □ Feather □ Non-Feather

Hobbies:____

MEDICAL HISTORY:

□ Thyroid Disease □ Diabetes □High Blood Pressure □TB

□ Kidney Disease □ Glaucoma □ Heart Disease □ Heartburn/Reflux

□ Depression □ Liver Disease □ Asthma □ Eczema □ Cancer

FAMILY HISTORY:

	Age	Asthma	Hayfever	Eczema	Hives	Sinus	Other
Mother:	___________	□	□	□	□	□	□
Father:	___________	□	□	□	□	□	□
Siblings:	___________	□	□	□	□	□	□
Children:	___________	□	□	□	□	□	□

Are there any medical conditions that run in your family?

____

PLEASE REMEMBER TO BRING THIS COMPLETED QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT.

Patient Signature:______________________________________ Date:_________________

Reviewed by:____

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PATIENT INFORMATION

Patient Name: ____________________________ Date of Birth: __/__/____ Sex: M ____ F ___

Marital Status: __S __ M__ D __W Social Security # (optional): __________________

Race/Nationality: __________________ Language: ________________

Home Address: __________________________ Apt #: _____ City: _________ State: ___ Zip: ____

Home Phone: ___________________ Cell Phone: _____________ Email Address: ______________________________

Employer: _____________________ Phone: _______________ Occupation: ___________________

Emergency Contact: ____________ Phone: _______________ Relationship: __________________

PRIMARY INSURANCE

Insurance Name: ____________________ Policy ID#: ______________Group #: _______________

Name of Primary Insured: _____________ Date of Birth: __/__/____ Relationship: ____________

SECONDARY INSURANCE

Insurance Name: ____________________ Policy ID#: ______________Group #: _______________

Name of Primary Insured: _____________ Date of Birth: __/__/____ Relationship: ____________

WHO REFERRED YOU TO OUR OFFICE? (*These physicians will receive a report of your visit*)

PHYSICIAN: _________________________________ **PHYSICIAN**: __________________________________

SPECIALTY: ________________________________ **SPECIALTY**: _________________________________

Address: ________________________________ Address: ________________________________

_________________________________ ________________________________

Phone: ____________ Fax: _____________ Phone: _____________ Fax:

ASSIGNMENT OF BENEFITS

CLAIMS AUTHORIZATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR ALL PATIENTS

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services, rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claims submitted to any health insurance carrier(s).

I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan; self-insurer or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is a group contract held by my employer, an association, trust fund, union or similar entity, this authorization shall become effective immediately, remain upon execution, and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until claim reaches final consummation. This authorization shall be binding upon my dependents, and my heirs, executors, administrators and me.

ADDITIONAL AUTHORIZATION FOR MEDICARE POLICYHOLDERS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

I have read the above agreement and authorize payment of medical and surgical benefits to be made on my behalf to my physician(s) in this office. I also understand that I am responsible for any balance remaining after all insurance coverage(s) has been secured.

Signature: ____ Date: _________________________________

Signature of Patient Representative: ___________________________ Relationship to Patient: ______________________

Attention New Patients with Deductibles:

If you have an in-network specialist deductible that has not yet been met, our office policy is to collect the deductible before seeing the doctor. The amount collected will be put toward the cost of the consultation.

Testing costs, such as PFT, intradermal or prick testing, will incur additional charges which, if not covered by the deductible, are your financial responsibility due on day of service.

Payment plans are available upon request.

Any monies submitted to us in excess of the fee determined by your insurance company will be refunded.

I have read and understand the Allergy & Asthma Care of Rockland, P.C.'s deductible policy described above.

____
Patient Name

________________________________ __________
Patient Signature Date

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PATIENT HIPAA AWARENESS NOTICE OF PRIVACY PRACTICES

With my permission, ALLERGY & ASTHMA CARE OF ROCKLAND, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Allergy & Asthma Care of Rockland, P.C. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Allergy & Asthma Care of Rockland, P.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Allergy & Asthma Care of Rockland, P.C. may call my home or other designated locations to leave a message on voice mail or in-person in reference to any topics that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements and any calls pertaining to my clinical care, including pathology and laboratory results, among others.

I have the right to request that Allergy & Asthma Care of Rockland, P.C. restrict how it uses or discloses my personal health information to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does agree, the practice is bound by this agreement.

By signing this document, I am allowing Allergy & Asthma Care of Rockland, P.C. to use and disclose my PHI for TPO and to review my prescription history.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with members of your family? YES NO
If YES, please name the members of your family with whom we are allowed to discuss your medical condition:

____

____

______________________________ ______________________________
Signature of Patient or Legal Guardian | Print Name of Legal Guardian, if applicable

______________________________ ______________________________
Patient's Name | Date

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign: ____

Communication Barriers: ____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of the terms of your insurance and of our Financial Agreement is important to our professional relationship. While we verify your coverage, it is not a guarantee of coverage for services rendered. You are bound by the terms of the claim settlement. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL PHOTOCOPY YOUR INSURANCE AND ID CARDS FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain one PRIOR to your appointment and have it with you at the time of your visit. If you do not have your referral with you at the time of the visit, you will be charged a cancelled appointment fee of $250.
- **CO-PAYMENTS** – By law, we MUST collect your carrier-designated co-pay amount. This payment is required at the time of service. The co-pay amount is due at each visit.
- **IN- or OUT-OF-NETWORK** – You will be responsible for any balance due as shown on your insurance carrier's Explanation of Benefits (EOB) form. We will adjust the charges to coincide with your plan's EOB. All patients will be responsible for their **co-insurance and deductible.** If we do not "participate" with your plan, payment will be expected at the time of service unless prior arrangements have been made with our financial staff. As a courtesy, we will send a bill to that carrier on your behalf and bill you the balance.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MINOR PATIENTS** – Each patient must have a designated party with fiduciary responsibility.
- **MISSED APPOINTMENTS**: If you do not show up for, or cancel an appointment with less than 24 hours' notice, you will be billed a missed-appointment fee of $25.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to promptly process payments. We reserve the right to send delinquent accounts to an outside collection agency.

We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS**.

Thank you for understanding our policies. Please feel free to ask any questions or share any concerns.

I have read and agree to the above agreement.

Print Patient Name: ______________________________ Patient Date of Birth: _______________

Patient Signature: ______________________________ Date: ____________________________

Guardian/Representative Name: _____________________Relationship: _____________________

Guardian/Representative Signature: ____