**PATIENT DATA FORM**

Patient’s

Last Name: First Name: MI:

**\*Preferred Name:** Sex: Date of Birth:

S.S # Marital Status: (S/M/D/W)

Address: City: State: Zip Code:

Home Phone: Work Phone:

Cell Phone: Email:

Emergency: Em. Phone:

Referring Dr.: Referring Dr’s #:

Pharmacy Name: Pharmacy number:

**Primary Insurance Coverage: Secondary Insurance Coverage:**

Insurance Co.: Insurance Co.:

Insured Name: Insured Name:

Relationship: DOB: Relationship: DOB:

Policy Number: Policy Number:

Group Number: Group Number:

**Responsible Party/Guardian/Guarantor**

Name:

Address: City: State: Zip Code:

Phone Number: Relationship to Patient:

**Patient’s Authorization**

I authorize **Advanced Asthma, Allergy, & Sinus Center** to apply for benefits on my behalf for services rendered by **Advanced Asthma, Allergy, & Sinus Center.** I request that the information I have reported, with regard, that my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

Print Name/ Signature of Patient/Parent/Guarantor Date

**Financial and Appointment Policies**

***For us to provide the best service to our patients, we are providing the following updated policies. Please initial each statement then sign and date at the bottom.***

**Financial Policy**

I acknowledge that I am responsible for my co-payment at the time of service. I am responsible for any deductibles or non-covered services and any outstanding balance on my account to be paid within thirty (30) days upon receipt of statement. A **$35 service fee** will be charged for any returned checks. I will be responsible for this fee along with any outstanding balances on my account.

**Initials:**

**Referrals**

If my insurance plan requires a referral, it is my responsibility to obtain one. If I do not provide a required referral for my office visit, my appointment will be rescheduled. The office staff will not call my primary care physician to obtain a referral.

**Initials:**

**Cancellation Policy**

Effective January 1, 2022, a 24-hour notification is required should I need to cancel or reschedule my appointment. If you are going to be later than your scheduled time, please be sure to contact our office to let our staff know of your arrival time. We only allow a grace period of **15 minutes**. Failure to show for an appointment at your scheduled time without notification will generate a **$25.00 fee**, which will be my responsibility. This is not covered by the insurance, and I will be fully responsible for this charge. We do understand that conflicts may occur, however, the more notice we receive, the better we can serve other patients in their need of medical care.

**Initials:**

**Medical Records**

In accordance with Maryland Law, there is a charge for copying medical records. This charge is $22.88 (includes administration fee). The price per copied page is .50 cent per page. The cost of mailing medical records is the actual postage value. Medical records to your physician are a courtesy. Medical release form from the requesting physician needs to be faxed from their office for this courtesy to apply.

**Initials:**

**Completion of FMLA, Work, Disability, School forms and letter fees**

There is a **$35.00** fee for any kind of form(s)/letters that requires the provider to complete. **(FMLA, WORK, COVID ACCOMODATION, DISABILITY FORMS & WORK, HOUSING, DISABILITY LETTERS).** There is a **$15.00** fee per patient for any **school form(s**) & a **$20** fee for **school letter(s)**. Payment must be made prior to releasing forms/letters. \*\***PLEASE ALLOW UP TO 2 WEEKS FOR THE COMPLETION OF ALL FORMS/LETTERS\*\***

**Initials:**

**Nurse Visit**

Please note that if a patient comes in without an appointment and or calls in to speak to a nurse, depending on the time and complexity of the visit/call, there may be a charge for the visit.

**Initials:**

**I have read the above policies, understand, and agree to comply.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/ Parent/ Guardian signature Date**

**O# 301-599-5401 F# 301-599-5403**

**NOTICE OF PRIVACY PRACTICES**

**YOUR PROTECTED HEALTH INFORMATION**

**Our practice is required by the Federal Privacy Rule to maintain the privacy of your health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required by the terms of the notice currently in effect.**

**This office reserves the right to change its practice and put into effect new provision that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify the patient.**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.**

**Patient Health Information:**

**Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.**

**Consent for Care:**

**I, with my signature, authorize AAASC, and any employee working under the direction of the physician, to provide medical care for me, or the patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.**

**How We Use Your Patient Health Information**

**Your health information will be used for treatment, payment, and health care operations, including administrative purposes and evaluation of the quality of care that you receive.**

**Treatment: Information obtained by our physician in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. The sharing of your information may progress to others involved in providing care. For example, we may disclose information to other health care providers who are participating in your treatment, or to pharmacists who are filling your prescriptions. It is our policy not to discuss your healthcare with family members except in the event of an emergency, or if there is an urgent situation and we are not able to reach you.**

**Payment: Your health care information will be used to receive payment for services rendered by this office. We will submit bills with accompanying documentation that identifies you, your diagnosis, and procedures performed to your health insurance carrier.**

**FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have any questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. RAA-AC2: lm-07/03**

**O# 301-599-5401 F# 301-599-5403**

Use and Disclosure of Protected Health Information

**PATIENT ACKNOWLEDGEMENT & CONSENT FORM**

**ACKNOWLEDGEMENT OF NOTIFICATION**

**The educational pamphlet “Notice of Privacy Practices” provides information about how AAASC and Rockville Allergy & Asthma may use and disclose protected health information about you and is compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).**

**Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.**

**You have a right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or healthcare options. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.**

*By signing below, you acknowledge receipt of our Notice of Privacy Practices.*

Patient/Guarantor Signature Date

**Consent for Use and Disclosure Information**

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

I request that payment of authorized Medicare/Insurance Carrier benefits made on my behalf to AAASC for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the center for Medicare/Medicaid Services and it’s agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plans as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient/Guarantor Signature Date

**Consent for Care**

I, with my signature, authorize AAASC, and any employee working under the direction of the physician to provide medical care for me, or the patient for which I am the legal guardian. This medical care may include services and supplies that may be related to my health (or identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Patient/Guarantor Signature Date

Print Full Name Date





**New Patient History**

Name: Birth Date: Today’s Date:

Please describe in a few words why you are here?

Occupation? If child, what grade?

Medications

What medications do you take on a daily or frequent basis, prescription and non-prescription, with doses if known. Include all pills, sprays, inhalers, and supplement.

Allergies

List any allergies to medications the nature of the reaction, and how long ago:

Environmental History (check one)

Do you live in a [ ] single family house, [ ] townhouse, [ ] or apartment?

Do you have carpet in the bedrooms? **[ ] yes [ ] no**

Do you have carpet in most of the house? **[ ] yes [ ] no**

Do you have central air conditioning? **[ ] yes [ ] no**

If you have a basement, has there ever been any mold damage? **[ ] yes [ ] no**

Do you have or are you around pets **[ ] yes [ ] no**

List all pets (indoor & outdoor) or animals you are frequently around:

Does anyone who lives in the home smoke? **[ ] yes [ ] no**

If patient is a young child, are they at the home during the day, in school, or with another caregiver?

**[ ] yes [ ] no if yes, please state which:**

Allergy History

Have you ever been diagnosed with asthma, allergic rhinitis (hay fever, “allergies”), or eczema?

**[ ] asthma [ ] allergic rhinitis (hay fever, “allergies”) [ ] eczema [ ] N/A**

When you were a young child, did you have allergies, asthma, or eczema? **[ ] yes [ ] no**

Have you ever been allergy tested **[ ] skin or [ ] blood?** When and what were you allergic to?

Have you ever been on allergy immunotherapy/shots **[ ] yes [ ] no**

Have you ever had a reaction to **[ ] Food? [ ] Latex [ ] Insect Stings**

If you do have allergies, what medications have you tried, and did they help?

**Initiating/Exacerbating Factors (things that make symptoms worse)**

Check those that apply

**Nasal (nose) Ocular (eye) Chest Dermal (skin)**

Day

Night

Outdoors

Indoors

Strong Odor

Smoke

Mowing Lawn

Raking Leaves

Cleaning House

Cat

Dog

Menstrual Cycle

Spring

Summer

Fall

Winter

**Family History**

Does anyone in your close and distant family have: please check who. (*Note: M = Maternal Relative, P = Paternal Relative*)



**Past Medical History**

What medical problems do you have?

Current Past

Eye Disease [ ] [ ]

Nasal Polyps [ ] [ ]

Croup [ ] [ ]

Emphysema [ ] [ ]

Heart Disease [ ] [ ]

Gastroesophageal reflux [ ] [ ]

Migraines [ ] [ ]

Hypertension [ ] [ ]

Thyroid Disease [ ] [ ]

Diabetes [ ] [ ]

Have you had [ ] nasal/sinus surgery? [ ] tonsillectomy/adenoidectomy? [ ] ear tubes?

If so, approximately when?

Have you ever had surgery? If so, when and what type?

Have you ever been hospitalized overnight for reasons other than surgery? If so, please list.

Have you ever had to visit the emergency room for any reason other than what is listed above?

If so, please list.

If patient is a child, was the born premature?

Have you ever been a smoker? If so, how many packs per day did/do you smoke, how many years and did you quit?

**If you have frequent Asthma:** N/A

Diagnosis of asthma made years ago (or at age: )

# of courses of antibiotics in the past year: # of Ear infections in the past year:

# of Sinus infections in the past year: Last sinus CT scan date (if any):

# of ER visits for asthma per year: Last ER visit:

# of courses of Prednisone for asthma: Last course:

# of missed work/school days per year:

Do you have a spacer for your inhaler: Do you use it?

**Review of Systems:**

Please check problems you have had recently (within the past 6-12 months)

Loss of Vision Coughing Rash

Itchy/Watery/Red Eyes Wheezing Hives

Difficulty Swallowing Shortness of Breath Swelling

Hoarse Voice Coughing up Phlegm/Blood Dryness/Itching (skin)

Nosebleeds Palpitations/ Irregular Heartbeat Depression

Sneezing Swelling of Ankles Sleeping Poorly

Nasal Congestion Heartburn Currently Pregnant

or Plan to be in the near future

Post Nasal Drip/Drainage Constipation

Headaches Bitter/Acidic Taste

**www.advancedasthmaallergy.com**

**Email:** [**bhatticares@comcast.net**](mailto:bhatticares@comcast.net)

**Fax: 301-599-5401**

**TELEMEDICINE/TELEHEALTH PATIENT CONSENT FORM**

* I , the undersigned patient, understand that I choose to have a telemedicine visit via the

internet, using Doxy.me, with the physician of the Advanced Asthma Allergy &

Sinus Center practice.

* I understand that I am responsible for the copay (for a specialist office visit) and any balances

not covered by my insurance company. These balances include any deductibles, coinsurance,

or insurance rejections. The telemedicine visit will be submitted by the practice to

my insurance company first before I am billed. Once the practice receives an Explanation of

Benefits, then I will be billed for any potential balances. ***(Please Note: All Self-Pay Patients will***

***be charged a fee of $75 for every Virtual Appointment and must be collected before each virtual appointment).***

* The practice is not responsible, due to COVID-19 & Federal Guidelines, for any violation

of internet privacy. The practice will do its best to ensure HIPAA compliance, but it is

not a guarantee since the consult/visit is done via the internet.

* The office visit will be documented in the patient’s medical records just like any other office

Visit.

* I understand that the physical examination part of the office visit will be limited due to the

video conversation.

* The provider will treat the telemedicine appointment visit like any other office visit (albeit

noting the limited physical examination and internet capabilities).

I understand that all of my questions have been answered to the best of the practice’s ability. I

will not hold the practice (Dr. Neena Bhatti of AAA & SC) in any liability

regarding the use of doxy.me, the internet browsers, and the telemedicine provider appointment/

visit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or Guardian, if patient is under the age of 18 years) Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date