ALLERGY, ASTHMA & SINUS ASSOCIATES

New Patient Information

PATIENT INFORMATION

Last Name:_____ First Name:_____Middle Name: _____

Birth Date:_____ Sex: _____ Race: _____ Ethnicity: _____

Billing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Marital Status: _____ Student Status (Y/N): _____ ❑ Veteran ❑ Smoker

Email: _____ Language: _____

Primary Care Doctor: _____ Telephone: _____

Referring Physician:_____ Telephone: _____

Pharmacy: _____ Telephone: _____

RESPONSIBLE PARTY INFORMATION

IF THE PATIENT IS A MINOR, the parent the child lives with is the responsible party:

Responsible Party: _____ DOB: ___ /_____ / _____

Address: _____

State: _____ Zip:_____ Telephone: _____

Employer:_____ Employer Telephone: _____ Occupation: _____

INSURED INFORMATION

PRIMARY Insurance Company: _____ **ID#:** _____

Name of Insured: _____ DOB: ____/ ____/_____ Gender: _____

Address: _____City: _____ State:_____ Zip: _____

Patient's Relationship to Insured (Self, Spouse, Child, Dependent, Other): _____ If 'Other' Please Specify: _____

SECONDARY Insurance Company**:** _____ **ID#:** _____

Name of Insured: _____ DOB: ____/ ____/_____ Gender: _____

Address: _____City: _____ State:_____ Zip: _____

Patient's Relationship to Insured (Self, Spouse, Child, Dependent, Other): _____ If 'Other' Please Specify: _____

Signature: _____ **Date:** _____

If patient is a minor, print name of parent/guardian: _____

Signature of parent/guardian: _____ **Date:** _____

ALLERGY, ASTHMA & SINUS ASSOCIATES

New Patient Information

Name: _____ **DOB:** ____/ ____/_____ **Date:** _____

What is the reason for visiting our office? _____

_____

1. REVIEW OF SYSTEMS: Do you have any of the following?

	YES	NO		YES	NO		YES	NO
Fever	☐	☐	Depression	☐	☐	Urine Problems	☐	☐
Weight Change	☐	☐	Thyroid Problems	☐	☐	Constipation	☐	☐
Blurred Vision	☐	☐	Diabetes	☐	☐	Nausea	☐	☐
Headaches	☐	☐	Urine Problems	☐	☐	Vomiting	☐	☐
Irregular Heartbeat	☐	☐	Thyroid Problems	☐	☐	Diarrhea	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
Hand Stiffness	☐	☐	Palpitations	☐	☐	Joint Swelling	☐	☐
Chest Pain	☐	☐	Night Sweats	☐	☐			

2. LIST OF MEDICATIONS:

Name	Dose	Frequency

3. Please list any medical conditions that you have: _____

_____

_____

4. Please list any surgeries that you have had: _____

_____

Allergy, Asthma & Sinus Associates, P.A. – Financial Policy

To best serve our patients, Allergy, Asthma & Sinus Associates is contracted with numerous insurance companies. While we are pleased to be able to provide this service to our patients, it is not possible for our staff to keep track of the individual requirements for each insurance plan. Since each insurance plan has different stipulations regarding access to care and payment for services received, we strongly recommend that patients speak with their insurance provider(s) and understand their benefits prior to their visit.

Our mission is to provide patients and their families with quality medical care.

We are happy to provide care for our patients, within the guidelines of their insurance contract, however we request that patients come prepared at the time of service with knowledge of these guidelines. With most of our insurance contracts, Allergy, Asthma & Sinus Associates personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide each insured person with quality care, **however it is the insured person's responsibility to understand their benefits and financial obligations.**

Should your insurance company require a specialist referral from your primary care physician before our physicians can see you, it is your responsibility to obtain that referral **prior to your appointment**. Patients may bring the referral with them at the time of their visit or request that the referral be send directly to our office by fax or email using the contact information listed on our website. Our contracts with such insurances prohibits us from seeing you without a referral and billing them for services. If you are seen without a referral, **you must be prepared to pay for all services in full at the time they are rendered.** If a referral is required and you are unsure as to how to obtain one, please let the staff know and we will be happy to provide assistance.

If you fail to inform us of any special requirements in your insurance contract, such as pre-authorization for treatment or referral requirements, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will likely deny payment for services received. **Please remember that you, the patient, are ultimately responsible for payment on your account.**

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

_____ _____

(Patient and/or Insured Signature) (Date)

_____

(Print Name)

ALLERGY, ASTHMA & SINUS ASSOCIATES

Acknowledgement of Receipt of Notice of Privacy Practices

Part 1:

Patient Name: _____

Address: _____

I have been given a copy of Allergy, Asthma & Sinus Associates *Notice of Privacy Practices* ("*Notice*"), which describes how my health information is used and shared. I understand that Allergy, Asthma & Sinus Associates ("*the Practice*") has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Practice website at www.allergysfl.com

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

_____ _____
(Signature of Patient or Personal Representative) (Date)

Print Name: _____

Relation to Patient (e.g., Self, Guardian): _____

Part 2:

Allergy, Asthma & Sinus Associates clinical staff may need to communicate Protected Health Information (PHI), such as test or lab results, via phone. Please let us know what phone number you would like us to call and if we may leave a message:

Phone Number: _____

_____ **Yes**, you may leave a message

_____ **No**, please do not leave a message

I authorize the Practice to include the following person(s) in any communication regarding my PHI. This is a valid authorization until I revoke this in writing:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ _____
(Signature of Patient or Personal Representative) (Date)

For Office Use Only: Complete this section if the patient or personal representative is unable or unwilling to sign the Privacy Acknowledgement, or if it is not signed for any other reason, state the reason:

Describe the steps taken to obtain the patient's or personal representatives' signature on the Privacy Acknowledgement:

_____

_____ _____
(Signature of Practice Representative) (Date)

ALLERGY, ASTHMA & SINUS ASSOCIATES

Patient Communication/Appointment Cancellation Policy/Rx History

Patient Name: _____ Date of Birth: _____

Patient Communication Options:

Allergy, Asthma & Sinus Associates (AASA) offers several options to receive practice communications such as appointment confirmations/reminders, clinical care reminders, and occasional practice updates such as office closings. These notifications are in addition to the messages you receive through your Patient Portal. If you have no activated your Patient Portal account, please call 954-717-1919 or provide your email address below. Our staff will assist in the activation of your portal account.

Check your preferred option(s) for receiving notifications from our office.

○ **Voice Call/Message** Phone Number: _____

Preferred Time Of Day For Phone Calls:

___ Morning ___ Afternoon ___ Evening

○ **Text Message** Cell Phone Number: _____

○ **Email** Email Address: _____

Appointment Cancellation Policy

_____
Patient/Legal Guardian Initials

When you make an appointment with Allergy, Asthma & Sinus Associates, we reserve that time slot especially for you. If you need to cancel your appointment with us, we ask that you give at least 24 hours notice. For appointments that are cancelled within less than 24 hours or for "no show" appointments, you may be assessed a $25 cancellation fee. This will be payable prior to your next visit.

Consent To Obtain External Prescription History

In order to provide our patients with the highest standard of care, it is necessary for our physicians to know your prescription medication history. Our electronic health record system will allow us to view your current and past medications, which can prevent negative interactions between drugs. (Please Check One Option Below)

_____ **I Authorize** AASA and its affiliated providers to view my external prescription history through the use of their electronic health record system, eClinicalWorks. My prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff of AASA, including prescriptions that may be going back a number of years.

_____ **I DO NOT Authorize** AASA and its affiliated providers to view my external prescription history through the use of their electronic health record system, eClinicalWorks.

I understand I can change my authorization by completing a new form at any time and the change will be effective when the new form is received by Allergy, Asthma & Sinus Associates, P.A.

_____ _____

(Signature of Patient/Authorized Representative) (Date)

_____

(Print Name)