ALLERGY ASSOCIATES OF HARTFORD, PC

Prasad Srinivasan, MD
Michael L. Krall, MD
Terry O'Donnell PA-C
Anakristia Bermudez, APRN

Dear Patient

Let us take this opportunity to thank you for the privilege of being able to render you professional care. You may have some questions regarding your first visit, which we will try to highlight.

Enclosed are forms we will need for you to fill out and bring with you on your first visit. Please also bring your insurance card, a photo ID (if a child the photo ID of the adult) and any necessary referrals on that visit. Please be prepared to pay for any co-pays or co-insurance that will be due at the time of service. Payments may be made by cash, check, MC, Visa or Discover.

It is absolutely necessary that all antihistamines, such as Allegra, Claritin, Clarinex, Zyrtec, Xyzal, Benadryl or other antihistamines be discontinued 48 hours prior to your appointment, unless you are experiencing a break out of hives. You should continue to take any medication prescribed by your physician for asthma, blood pressure, diabetes, heart disease, etc. During your first visit if the doctor feels it is necessary we will begin allergy testing with either a scratch test and/or an intradermal test. The sensation felt on testing is comparable to a mosquito bite or pinprick. We then look for a reaction on the skin after 15-20 minutes observing for any evidence of redness, hives or itching. Your initial visit will take approximately 60-90 minutes. Testing may take multiple visits to complete. If you are requesting special testing for foods, medications, metals, etc, these will take several visits to complete.

If you are unable to keep an appointment, please call as far in advance as possible so we may schedule another patient in your place.

If you require the services of a service animal, please notify our office prior to your appointment so that we may make accommodations to assist you while ensuring the health and safety of others in our offices, many of whom are asthmatic and/or severely allergic to dog dander.

Please feel free to ask us any and all questions you may have. In the event of any emergency we are on call 24 hours. You may also visit our patient portal at www.aahmd.com. We can provide you with a user name and password to check out your visit summary, your account, request refills and even schedule and appointment.

Welcome to our Practice!

Prasad Srinivasan, MD Michael L. Krall, MD

Terry O'Donnell, PA-C Anakristia Bermudez, APRN

19 Woodland Street
Hartford, CT 06105
860.246.7273

300 Hebron Ave
Glastonbury, CT 06033
860.659.8904

105 West Road
Ellington, CT 06029
860.875.7660

862 East Main Street
Meriden, CT 06450
203.440.9190

PATIENT INFORMATION

Date:_____

Name:_____
(LAST, FIRST, MIDDLE INTIAL)

Address_____

City:_____

State:_____ **Zip Code:**_____

Home Phone: _____ **Cell:**_____

□ Ok to receive text message reminders

Email address: _____

□ Ok to receive email reminders/messages

Social Security: _____

Sex o M o F Age: Birthdate:

o Married o Widowed o Single o Minor
o Separated o Divorced o Other

Occupation:_____ or Student /Retired

Employer Name & Address_____

_____

Employer Phone Number: _____

Primary Care Physician:_____

Primary Care's Phone Number: _____
Were you referred by your Primary Care Physician? Yes No

In case of an Emergency Contact:

Name:_____

Relationship:_____

Home Phone:_____ Work:_____

Cell:_____

INSURANCE

Who is responsible for this account? (if child must be parents/guardians name)

_____

SS#: _____Relationship to Patient:_____

Address_____

City:_____

State:_____ Zip Code:_____

Home Phone: _____ Cell:_____

Primary Insurance:_____

Policy ID_____Group ID:_____

REFERRAL REQUIRED?:_____

Card Holders Name:_____

DOB:_____SS#_____

Employers Name:_____

Secondary Insurance:_____

Policy ID:_____ Group ID:_____

REFERRAL REQUIRED?:_____

Card Holders Name:_____

DOB:_____SS#_____

If patient is minor child, child lives with:
Both parents One parent Grandparents Guardian Other

I also acknowledge that I DID / DID NOT receive a copy of Allergy Associates of Hartford, PC's privacy notice.

Signature:_____

Date:_____

Reason for today's visit:_____
Do you have a history of:
o Allergies o Asthma o Hives o Rashes o Food/Drug/Insect Allergy

Please list all known Allergies:_____
Pharmacy:

PLEASE FILL FORM OUT COMPLETELY

Patient Name:_____Date:_____
Pharmacy: (Name, town)_____Phone:_____
Reason for today's visit:_____
Smoking: Y or N Packs per day_____ for how many years?_____
Is there anyone living in the house that smokes? Y N Is the patient exposed to second hand smoke? Y N
Alcohol consumption: Y or N Socially Y or N Any history of substance abuse? Y or N
Please list all known allergies

Food, medication, insect, etc	Reaction:

Please list all medications you are currently taking

Name of medication	Purpose of medication

Past Medical History: Have you ever had? Circle yes or no,

Hay Fever	Y or N	Sensitivity to Food	Y or N	Allergy testing	Y or N	Diabetes	Y or N
Asthma	Y or N	Sensitivity to drugs	Y or N	Allergy shots	Y or N	Tingling in hands	Y or N
Hives	Y or N	Sensitivity to stings	Y or N	High Blood pressure	YorN	Bruising problems	Y or N
Skin rashes	Y or N			Heart Disease	Y or N	Pneumonia	Y or N
Sinusitis	Y or N	Chronic or Acute?		Frequent Urination	Y or N		
Are you currently taking any beta blockers? Y or N				Are you taking any cholesterol mediations? Y or N			

Do you have now or had in the past 30 days? Circle yes or no

Unexplained Fever	Y or N	Nasal Itching	Y or N	Ringing in ears	Y or N	Cough w/ exercise	Y or N
Chills	Y or N	Stuffiness	Y or N	Vertigo	Y or N	Wheezing	Y or N
Weight loss or gain	Y or N	Loss of Smell	Y or N	Discharge from ears	YorN	Chest congestion	Y or N
Fatigue	Y or N	Post Nasal Drip	Y or N	Sore throat	Y or N	Tingling in hands	Y or N
Headaches	Y or N	Dry Eyes	Y or N	Freq clearing throat	Y orN	Rash	Y or N
Sinus Pain	Y or N	Itchy eyes	Y or N	Swollen glands	Y or N	Itching of the skin	Y or N
Swelling of the lips	Y or N	Red Eyes	Y or N	Chest pain	Y or N	Hives	Y or N
Loss of taste	Y or N	Watery eyes	Y or N	Shortness of breath	Y orN	Eczema	Y or N
Bloody nose	Y or N	Swelling of eyelids	Y or N	Cough	Y or N	Anxiety	Y or N
Sneezing	Y or N	Drainage from eyes	Y orN	Cough w/play	Y or N		

Family History: Has any blood relative had the following? Circle yes or no Who?

Allergies	Y or N	Diabetes	Y or N	High blood pressure	YorN
Asthma	Y or N	COPD	Y or N	Heart Disease	Y or N

Patient Name:_____ **Date:**_____

Home Environment: Does your house have?

Do you live in		Age of home:		Cat Y or N #?		Other animals	Y or N
House	Y or N	A/C	Y or N	Dog Y or N #?		Plants	Y or N
Apt/Condo	Y or N	Carpeting	Y or N	Bird	Y or N	Type of heating:	

Have you ever seen:

ENT	Y or N	Who	When:
Dermatologist	Y or N	Who	When:
GI	Y or N	Who	When:
Neurologist	Y or N	Who	When:
Other specialist	Y or N	Who	When:

Hospitalizations/ER visits:

Asthma How many?	Y or N	Intubations?	Y or N	ER visits for Asthma: How many?		Insect Stings? Food allergy?	

Have you been out of the country in the last 3 months? Yes No

Have you been to West Africa recently? Yes No Do you have any communicable diseases Yes No

When did symptoms first occur? How long have they been bothering you?

How severe are they?

How long do they last?

Are you aware or any triggers? Things such as:

Dust	**Pets**	**Laughing**	**Work**	**Winter**	**Mornings**	**Foods**
Mold	**Cold Air**	**Crying**	**Home**	**Spring**	**Night Time**	**Medicines**
Grass	**Water**	**Exercise**	**Fall**	**Summer**	**Strong Smell**	**other**

Is there anything else which might be important for the doctor to know about your symptoms, medical, family or food history?

Allergy Associates of Hartford, PC

FINANCIAL AGREEMENT

I have requested treatment from Allergy Associates of Hartford, PC. I have read and understood the following:

1. I authorize direct payment to Allergy Associates of Hartford, PC of any group or individual medical insurance benefits to which I may be entitled and otherwise payable to me in order to satisfy my obligation to pay the charge for me, my child's/spouse/dependent's services rendered in the office.
2. Although we are contracted with many insurance companies, it is your responsibility to ensure that our physicians are in your plan. I understand it is my reasonability to know my insurance benefits. My insurance may not cover the full cost of my services, including copays, co-insurance, deductibles, and non-covered services. If I have a HIGH DEDUCTIBLE PLAN, I know my deductible amount and understand that my services will be processed under the deductible for which I am responsible for.
3. I am responsible for all copayments, deductibles and co-insurance as per the terms of my contract with my insurance carrier.
4. All copayments must be paid at the time of service. This includes multiple copayments for testing (if required by my insurance carrier) as well as predetermined coinsurance (i.e. for allergy injections). I understand that if I do not pay my co-pay at the time of service I may be charged a statement fee. This does not apply for co-insurance or deductibles.
5. I am responsible for obtaining any and all required referrals for service. I understand if I have services rendered to me and I do not have the proper referral in place I will be responsible 100% for the outstanding bill.
6. I am responsible for all non-covered services. The office will do its best to inform me of any service that will not or may not be covered. However, I understand that benefits are not determined by my insurance carrier until after the claim is submitted; therefore there is no guarantee of payment by my insurance carrier.
7. I am responsible for updating my health insurance information with the office any time the information changes/terminates/ new coverage begins. The office will submit my medical claims for me as per the terms of the contract with my insurance carrier.
8. The office is restricted to a "timely filing" period. I understand that I must provide my health insurance carrier information in a timely fashion, so that the claim may be paid. Any claim unpaid because I did not supply the office with my information in a timely fashion is my responsibility and I am responsible for payment.
9. Payment plans are available based on financial necessity. I understand that I must speak with the billing office to establish a payment plan.
10. Fees associated with allergy serum, are my responsibility. Should I choose to discontinue allergen immunotherapy or not use the prepared serum, I am still responsible for these fees, once the serum is prepared. Serums are prepared once I agree to start the program of immunotherapy. I understand that this office is bound by their contract with my insurance carrier and that any limits that are set are set by my insurance and not by the office.
11. A check returned from my financial institution is subject to a returned check fee. This fee is based on the current rates set by the offices financial institution. A mailed in credit card payment that is denied will also be charged a return fee.
12. Any account balance over 60 days is subject to collections proceedings. A 15% processing fee will be assessed to an account each time a balance is turned over for collections up to a maximum of $20.00.
13. I understand that my insurance company may have limits for my treatment and that this office will work with me to the best of their ability to work within those guidelines. I understand as the insured it is my responsibility as well to know any limitations that my insurance company may have for allergy treatment.
14. All forms/reports require a 10-14 day business turnaround time. This includes school forms. The following fees will apply to all forms: FMLA $10 School forms $5 if expedited. Letters/reports/other forms $10 per letter/form.
15. I understand all credit balances under $200 will be kept on my account until either it can be applied to future dates of services of until I call Allergy Associates of Hartford's billing company and request a refund of my account. I understand that refunds take up to 30 days to process.

Patient Name:_____

Patient/Parent/Guardian/ Signture:_____

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This office has always made it a policy to protect your privacy however the federal government now requires that we notify our patients of this fact and have a patient or guardian sign an acknowledgement to be kept as a permanent part of the medical record stating that this notification has been given. The complete Privacy Practice Notice for this office is on display in the waiting room or a copy can be given to you to read at your convenience.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Relationship to Patient:_____

Signature:_____

*** Patient: Please indicate below if you allow Allergy Associates of Hartford, PC to release or discuss your medical information with another party. (eg: Appointments, billing, prescriptions...etc) If you wish for your spouse or if you are over the age of 18 and wish for a parent to be able to speak to us regarding your bill or care this must be filled in. If we do not have this information, we will be unable to speak to them.**

May Release Info To:_____

May release: Appointment Info Billing information Prescription info Other information

Relationship to Patient:_____

Patient Signature:_____ Date:_____

<u>Authorization to Release Medical Information and Claim Authorization</u>

I hereby authorize Allergy Associates of Hartford, PC to release any information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I hereby assign all medical and/ or surgical benefits to which I am entitled including private insurance and other health benefit plans to Allergy Associates of Hartford, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Date: _____ Signature:_____