Initial Visit Form

Allergy, Asthma & Sinus Center of Long Island
Harshit M. Patel, M.D.
Tel#: (516) 822-6655 Fax #: (516) 932-2090

Personal Information

*Name: _____
Last First MI

*Address: _____
Street

_____
City State Zip

*Social Security #: _____ - _____ - _____

Age: ____ *Date of Birth: ___/___/___ *Sex: Male Female

Marital Status: Single Married Separated Divorced Widowed

*Ethnic: Hispanic/Latin Non Hispanic/Latin Refuse to Report

*Race: White Hispanic/Latin Afr. American/Black Asian Other
Refuse to report

*Language Spoken: Hindi Tamil Spanish English Other

*Home phone: _____

Mobile Phone: _____

*Email: _____

Employer: _____

Employer Phone: _____

*In Case of Emergency Notify: _____

*Relation: Emergency Phone: _____

*Referring Physician: _____

*Primary Physician: _____

*Physician Phone: _____

Parent/Legal Guardian Information

Social Security #: _____ - _____ - _____

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

Driver's License: _____

Age: _____ DOB: ___/___/___ Sex: Male Female

Home Phone : _____

Work Phone: _____

Mobile Phone: _____

Relationship: Mother Father Guardian Other: _____

Primary Insurance Information

Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber's SSN: _____ - ____ - _____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: ____ /___ / ____

Subscriber's Effective Date: ____ /____/_____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____
Street

_____
City State Zip

Employer's Phone #: _____

Secondary Insurance Information

*Insurance Name: _____

Type: HMO PPO/EPO POS Other: _____

*Subscriber's Name: _____

*Subscriber's SSN: _____ - ____ - _____

*Relationship: Self Parent Guardian Spouse Other: _____

*Subscriber's DOB: ____ /___ /____

Subscriber's Effective Date: ____ /___/____

*Policy Number: _____

*Group Number: _____

Subscriber's Employer: _____

Employer's Address:

_____
Street

_____
City State Zip

Employer's Phone #: _____

Whom may we thank for referring you?

- ☐ Physician Office : _____
- ☐ Relative or Friend: _____
- ☐ Insurance Provider Directory
- ☐ Yellow Pages
- ☐ Other: _____

Receptionist will require a copy of your Insurance card and picture ID

We accept various methods of payment including Cash / Check / Credit Card

Consent and Disclosures Form

Allergy, Asthma & Sinus Center of Long Island

Harshit M. Patel, M.D.

The following two pages outlines our billing policies, authorization for treatment, assignment of benefits, release of medical information, and our privacy policy to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Billing

I (patient, parent, or legal guardian) understand that if the current insurance information is not received at the time of service, I will be responsible for full payments at the time of services are rendered.

If I am a self-pay patient, I am financially responsible for all services received and that payment is expected at time service is rendered.

In the situation of third part financial responsibility to cover the cost of your visit, the primary and ultimate responsibility for payment rests with you (patient, parent, or legal guardian).

We are contracted with several managed care plans (**P**referred **P**rovider **O**rganizations, **H**ealth **M**aintenance **O**rganizations, and **I**ndependent **P**hysician **A**ssociations). We must follow the terms of these plans including their financial relationships and **mandatory co-payments** and **deductibles**, which are required at time service is rendered.

There will be a billing service fee of $10.00 if **mandatory co-payments** and **deductibles** are not paid at the time of service.

There will be a $20.00 fee for each **bounced check**.

In result of a non-paid outstanding balance, your account balance will be forwarded to a **collection agency** and we will charge a $50.00 collection fee.

Regarding federal programs (Medicare and New York Medicaid), we have agreed to accept as full payment the government's discounted payment schedule. You are responsible for any **mandatory co-payments and deductibles** at the time of service (although you may have supplemental co-insurance which may cover the co-payment).

I (patient, parent, or legal guardian) understand that it is my responsibility of bringing in a **valid referral** at the time of services rendered. If not, I will be fully responsible for the services rendered.

This office confirms appointments as a courtesy; it is your responsibility to keep your appointment. If you are not able to keep your schedule appointment, please give us 24 hours' notice. Missed Appointment Charge/NO SHOW CHARGE $25.00 (NOT APPLIED TO ALLERGY SHOT PATIENTS).

Authorization for Treatment

I hereby voluntarily consent to medical care for the above names patient encompassing diagnostic procedures and medical treatment by the physician, his/her assistants, or designees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Assignment of Benefits

I hereby assign to Harshit M. Patel, M.D., P.C. all rights, title, and interests in the benefits payable to me by an insurance policy (ies) or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance.

_____ _____ - _____ - 20____

Signature of Patient/Parent/Legal Guardian Date

Notice of Privacy Practices

Allergy, Asthma & Sinus Center of Long Island

Harshit M. Patel , M.D.

The Health Insurance Portability & Accountability Act ("HIPPA") is a program allows significant rights to understand and control how your health information is used. "HIPPA" provides penalties that misuse personal health information. The following describes how we may use your information. I authorize Harshit M. Patel, M.D., P.C. to use and disclose personal medical information for each of the following purposes: treatment (i.e., among health care providers), payment (i.e. insurance companies), and health care operations (i.e. internal quality control). Dr. Patel may release medical information to the insurance carrier, Social Security Administration, third party administrators, referring physician, or any party that may be liable for all or part of medical charges information as may be necessary for enabling the determination of benefits available to the patient for the services rendered during this period of care. Dr. Patel may also create and distribute de-identified health information by removing identifiable information. Any other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing, except to the extent that we have already taken actions relying on your authorization.
I authorize Harshit M. Patel, M.D., P.C. to release information to our selected medical institutions and hospitals for laboratory, audiological, radiological, surgical, allergic, or other ancillary medical services as may be necessary for scheduling, billing, or determination of benefits available to the patient for the services rendered during this period of care. We may contact you to provide appointment reminders or health-related benefits that may be of interest to you.

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

I understand that I have a right to inspect or receive a copy of this authorization, an account of disclosures of my health information, or my personal health information upon my request.

I understand that billing statements and correspondence from our office will be sent to the address listed on the previous page.

I understand that confidential messages (i.e. appointment reminders) may be left on your home answering machine or voice mail at the phone numbers listed on the previous page (home, work, or mobile phone numbers) unless you request us not to.

I understand that diagnosis or treatment of me by Harshit Patel, MD may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, including those related to disclosures to family members, other relatives, friends, or anyone identified by you. Harshit Patel, MD is not required to agree to the restrictions that I may request. However, if Harshit Patel, M.D. agrees to a restriction that I request, the restriction is binding on Harshit M. Patel, M.D., P.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Harshit M. Patel, M.D., P.C. has acted in reliance on this consent.

I understand I have a right to review Harshit M. Patel, M.D. Notice of Privacy Practices prior to signing this document. The Harshit Patel, M.D. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Harshit M. Patel, M.D., P.C. Harshit Patel, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

This authorization shall become effective immediately and shall remain in effect for 2 years.

I understand that you have recourse if you feel that your privacy protection has been violated. You have the right to file a written complaint to our office, the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I also authorize the following relatives, friends, or other people that may be informed about my general medical condition or diagnosis:

Name: _____ Name: _____

_____ _____ - _____ - 20__

Signature of Patient/Parent/Legal Guardian Date

Exhibit 1(a)

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Harshit M. Patel Physician MD PC** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Harshit M. Patel Physician MD PC** to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for **Harshit M. Patel Physician MD PC** to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Healthix **Exhibit 1(a)**

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call **Harshit M. Patel Physician MD PC**; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

Initial Visit Form

Allergy, Asthma & Sinus Center of Long Island
Harshit M. Patel, M.D.
Tel#: (516) 822-6655 Fax #: (516) 932-2090

Name: _____

Appt Date: _____

Date of Birth: _____

To be completed by patient

Describe in your own words the reason for your visit:

_____

_____

_____

Pharmacy Name:

Address/Town:

Phone Number:

Current Medications: Please list all medications that you are currently taking, including over-the-counter medications:

1.

2

3.

4.

5.

6.

7.

8.

9.

Primary Physician: _____

Referred By: _____

To be completed by physician:

Chief Complaint:

History of Present Illness:

Associated Symptoms:

Nasal: ITCHY RUNNY CONGESTED SNEEZING SNORING MOUTHBREATHER NOSEBLEEDS

Sinus: HEADACHE PRESSURE INFECTIONS

Ear: ITCHY POPPING OM TUBES HEARING L(

Eye: ITCHY RUNNY SWELLING REDNESS

Throat: ITCHY PND HOARSENESS STREP

Chest: COUGH WHEEZE TIGHTNESS SOB BRONCHITIS PNEUMONIA

Skin: ITCHY HIVES ECZEMA

Other:

Initial Visit Form

Allergy, Asthma & Sinus Center of Long Island
Harshit M. Patel, M.D.
Tel#: (516) 822-6655 Fax #: (516) 932-2090

Name: _____

Appt Date: _____

To be completed by patient:

Medical History:

1. Have you ever had nasal or sinus surgery?
   ¨ Yes | ¨ No Type:
2. Have you had a tonsillectomy or adenoidectomy?
   ¨ Yes | ¨ No Type:
3. Have you ever had ear tubes?
   ¨ Yes | ¨ No Dates:
4. Have you ever been tested for allergies?
   ¨ Yes | ¨ No
   If so, did you have Skin Tests of RAST (Blood) tests?
5. Have you ever had allergy injections?
   ¨ Yes | ¨ No Dates:
   Did they help?

6. List ALL drug allergies:

7. List ALL food allergies:

For children under 15, please complete the following:

1. Birth Weight:
2. Were there any complications following delivery?
   ¨ Yes | ¨ No Explain:

3. Are immunizations up to date?
   ¨ Yes | ¨ No

To be completed by physician: _____

Family History:

	Father	Mother	Sibs	Children
Asthma				
Allergies				
Hives				
Eczema				
Cancer				
Other				

Physical Exam:

WT: _____ HT: _____

T: _____ P: _____ BP: _____

General Appearance:

EYES: CONJUNTIVA- NORMAL R L ; RED R L
LIDS- NORMAL R L ; EDEMA-

EARS: TMS- NORMAL R L ; DULL R L ; RED R L
CANALS- NORMAL OCCLUDED

NOSE: MUCOSA- NORMAL PALE RED
EDEMA- R- MILD MODERATE SEVERE
L- MILD MODERATE SEVERE
MUCOUS- MILD MODERATE COPIOUS
SEROUS WHITE MUCOID
POLYPS- NONE ; PRESENT R L
SEPTUM- MIDLINE ; DEVIATED R L
EXCORIATED R L ; PERFORATED

OROPHARYNX: PALATE- NORMAL OTHER:
POST PHARYNX- NORMAL INJECTED
COBBLESTONED PND

TEETH & GUMS: NORMAL ; OTHER:

FACE/SINUS TENDERNESS:
ABSENT FRONTAL MAX

NECK: NORMAL APPEARANCE

THYROID: NORMAL ENLARGED

LYMPHATICS: NECK AXILLA GROIN

CHEST: VENTILATION- NORMAL RETRACTIONS
AUSCULTATION- NORMAL
WHEEZES R L BILAT FVC
RHONCHI R L BILAT

Initial Visit Form

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To be completed by patient:

Check the following medical conditions that you have Currently:

Asthma: ☐ Rhinitis ☐ Nasal ☐ Congestion ☐ Sore Throat ☐ Cough
Constitutional: ☐ Fever or Chills ☐ Fatigue
Heent: ☐ Eye Pain ☐ Blurry Vision ☐ Hoarseness
Respiratory: ☐ Cough ☐ Wheezing
Cardiovascular: ☐ Chest Pain ☐ Palpitations
Gastrointestinal: ☐ Nausea ☐ Vomiting
Urology: ☐ Dysuria ☐ Urinary Frequency
Musculoskeletal: ☐ Joint Stiffness ☐ Muscle Pain
Dermatology: ☐ Eczema ☐ Hives
Neurology: ☐ Weakness ☐ Headache
Hematology: ☐ Fatigue ☐ Swollen Glands
Endocrine: ☐ Weight Fluctuations ☐ Heat Intolerance ☐ Cold Intolerance
Psychology: ☐ Anxiety ☐ Depression

Please list all hospitalizations (including year and reason).
1.
2.
3.

Social History:
Current Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Hobbies: _____
_____
Cigarette Smoking History: _____
Alcohol Use History: _____
How many drinks per day? (Circle one) 1 3 5+
Other: _____

Environmental History (Please Check the appropriate boxes):
Home: ☐ House ☐ Apartment ☐ Condo
☐ Mobile Home Age:_____
Pets: ☐ Cat ☐ Indoor ☐ Outdoor
☐ Dog ☐ Indoor ☐ Outdoor
Smokers: ☐ None
☐ Indoors By:_____
☐ Outdoors By:_____
Heat: ☐ Central ☐ Radiator
Air conditioning: ☐ Central ☐ Window
Pillows: ☐ Feather ☐ Non-feather Age:___
Bed: ☐ Mattress/Boxspring ☐ Waterbed
Age: _____
Flooring: ☐ Hardwood ☐ Carpet Age:____
Basement or Crawlspace:
☐ Dry ☐ Damp ☐ Musty

Patient: _____

Appt Date: _____

Physical Exam (Continued)
CVS: * Heart-
*PV (Observ/Palp)-

Abdomen: *Tenderness Mass-
* Liver/Spleen Normal Enlarged

Extremities:

Skin: Normal Other:

Neuro/Psych: *Orientation-
*Mood/Affect-

Other:

Labs/X-Ray:

Assessment/Plan:

1.

2.

3.

RTC: _____

By: _____