NEW YORK ALLERGY AND ASTHMA, PLLC

261 East 78th Street 4th Floor New York, NY 10075
Tel. 212-517-3300 ♦ Fax 212-517-3303

Patient's Name _____
(LAST) (FIRST) (M)

Age_____ DOB___/___/___ Sex: M F Marital Status:_____ SS#: _____

Address _____

City, State, Zip _____ Email: _____

Home # (____)_____ Work# (____)_____ Cell # (____)_____

Employer _____ Occupation_____

Employer Address _____

Primary Insurance_____Phone # (___)_____

Insurance Address_____

ID #_____Group # _____

Name of Insured_____Employer_____Relationship_____

Insured's Social Security_____Date of Birth_____

Referral Required Y N Copay $_____

Secondary Insurance_____Phone # (___)_____

Insurance Address_____

ID #_____Group _____

Name of Insured_____Employer_____Relationship_____

Insured's Social Security_____Date of Birth_____

Referral Required Y N Copay $_____

Referring Physician/Person _____ Phone #(____)____

Primary Care Physician _____ Phone #(____)____

Pharmacy _____ Phone #(____)____

I hereby authorize New York Allergy And Asthma PLLC, to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named Physician of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney/collection agency for collection, that I will be responsible for collection fees, attorney's fees, and court cost and interest.

Signature _____ Date _____

Patient/Guardian Signature

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may used or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign you name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: :Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicate in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for

notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physicians believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Shelisha Ramnarine, our HIPAA compliance officer. **We will not retaliate against you for filing a complaint.**
This notice was published and become effective on/or before **April 14, 2003.**

Acknowledgement of Receipt of Notice of
Privacy Practices

I have been presented with a copy of the Notice Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. **I agree that New York Allergy & Asthma may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefits payors for treatment purposes.**

Signature below is only acknowledgement that you have received this Notice of our Private Practices:

Patient's Name:_____

Signature:_____ **Relationship (if not patient)**_____

Date:_____

Internal Use Only

If patient/patient's representive refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date)_____ **(time)**_____

By (name)_____ **(title)**_____

Signature:_____

NEW YORK ALLERGY AND ASTHMA, PLLC

186 East 76 Street ♦Suite 2 ♦ New York, NY 10021
Tel. 212-517-3300 ♦ Fax 212-517-3303

CANCELLATION POLICY

Missed Appointment

Please note that the office visit scheduled with Dr Sebastian Lighvani at New York Allergy And Asthma must be cancelled at least twenty four hours prior to the appointment date to avoid a cancellation fee. You will be Billed $50.00 for missed appointment.

I_____ am aware that I am required to notify New York Allergy And Asthma during office hours (Monday- Friday between 9:00a.m.-5:00p.m.) of cancellations within at least twenty four hours of my scheduled appointment.

_____

Patient Name **D.O.B.** **Date**

_____

Signature

INITIAL ALLERGY EVALUATION FORM

Patient Name:_____ **Age:**____**D.O.B:**_____ **Date:** _____

Referring Physician:_____**Telephone:**_____

Primary Care Physician:_____ **Telephone:**_____

Answer All Sections Relevant To Your Condition

Please LIST all the reason(s) for your Visit:

_____

_____

_____

_____

_____

Answer the sections that apply to your condition(s):

NASAL & EYE ALLERGY HISTORY:

DO NOT WRITE IN THIS AREA

Circle the following <u>if they apply to you</u>:

Sneezing Itchy nose Itchy eyes Nasal congestion

Post nasal drip Cough Loss of smell Headache Ear problems

Facial Pain Runny Nose Clear/Yellow/Green Other:

Approximate Date of Onset of your Nasal symptoms:

When are your symptoms present?_____

Spring Summer Fall Winter All Year

Suspected triggers of your symptoms:

Trees Grasses Weeds Mold Dust Cat Dog Latex

Foods Aspirin/Advil/Motrin Colds Cold air Smoke Odors

Fumes/Perfume Beer Wine Other:_____

What Medications have you tried and their effects:

_____ _____

_____ _____

Have you ever been tested for Allergies? Yes/ No

Dates:_____Effect:_____

Dates:_____Effect:_____

Have you ever been on Allergy Shots? Yes / No

Dates:_____ Effect:_____

Dates:_____ Effect:_____

SINUSITIS HISTORY:

DO NOT WRITE IN THIS AREA

Number of Sinus Infections last year treated with Antibiotics:

NONE 1-2 3-4 4-5 >5

List Antibiotics Most Commonly Used: _____

Duration of a Typical Sinus Infection:

NONE 7-10 days 14-21 days 3-6 weeks Other:_____

Do you have a prior history of SINUS SURGERY or NASAL POLYPS? Yes / No

ASTHMA, WHEEZING, CHRONIC COUGH, BRONCHITIS:

Description of Symptoms:

Wheeze Cough Shortness of Breath Chest tightness Throat tightness

Phlegm Worse at night Worse during day Shortness of breath w/Activity

Date of Onset of symptoms: _____

Frequency of Daytime Asthma Symptoms over the last month:

None ≤2 days/week 3-6 days/week Everyday Continuously

Do your asthma symptoms wake you up at night?

Never ≤2/month >2/month >1/week Frequent

Emergency Room visits for asthma:

None 1-2 3-4 >5 Within last year

Hospitalizations for asthma:

None 1-2 3-4 >5 Within last year

Please Circle all of the following that CAUSE and/or WORSEN your respiratory symptoms:

Viral Infections Exercise Pollens Dust Mold

Animals Medications Smoke Cold Air Foods: (specify)

Latex Emotions Menses Sinusitis Acid Reflux

Please list ALL medications taken for this, how often and effects:

_____ _____

_____ _____

Please indicate how often you use your RESCUE inhaler: (e.g. Albuterol)

None <1/week 1-2 x /week 3-6 x /week daily # _____

Have you been prescribed any STEROIDS for Asthma Condition?

Never 1-2 times 3-5 times >5 times within last year

DO NOT WRITE IN THIS AREA

Do you suffer from HEARTBURN, INDIGESTION or ACID REFLUX: Yes No

Please circle if apply to you:

Throat clearing Hoarseness Cough Choking Burping Indigestion

Difficulty Swallowing Acid in the mouth

How many caffeinated drinks/day? _____ Coffee/Soda

How late in the evening do you eat? _____

Do any of your symptoms worsen after you eating? Yes / No

Skin Conditions: (Describe Rash/Date of Onset/Location/Triggers) **None**

ECZEMA HIVES RASH SWELLING Other:

_____ _____

_____ _____

How often do you have this problem?

Less than weekly 1-2 days per week 3-6 days per week daily

Known or Suspected cause of the rash:

Treatments tried so far and response:

Are you taking an ACE-Inhibitor? Yes / No

FOOD ALLERGY: (Describe reactions/Food/Amount/Time course/Treatment) **NONE**

_____ _____

_____ _____

Have you ever received or been prescribed an
EPINEPHRINE Injection (EPIPEN): Yes / No

INSECT ALLERGY: (Describe Reactions) **NONE**

_____ _____

_____ _____

DRUG ALLERGY: (Describe reactions) **NONE**

_____ _____

_____ _____

LATEX/RUBBER ALLERGY: (Describe reactions) **NONE**

_____ _____

_____ _____

INFECTION/IMMUNIZATION HISTORY:

DO NOT WRITE IN THIS AREA

Childhood Immunizations up-to-date? Yes No

Annual Flu Vaccine? Yes/ No **Pneumovax?** Yes/ No **TB skin test?** Yes/ No

Please Circle All Conditions that you have experienced:

Frequent Sinus Infections Frequent Throat Infections Fequent Ear Infections

Frequent Bronchitis Frequent Pneumonia Severe Infections: _____

Immune disorder Early Death in Relatives Abnormal Chest X-Ray

PAST MEDICAL HISTORY:

Please Circle All Medical Conditions that you have experienced:

High Blood Pressure	Heart Disease	Migraine
Gastrointestinal	Seizures	Cancer
Hepatitis	Diabetes	Stroke
Osteoporosis	Tuberculosis	Elevated Cholesterol
Thyroid Disease	Severe Infections	Positive PPD
Kidney Disease	Other:	

LIST ALL HOSPITALIAZTIONS/SURGERIES: NONE

_____ _____

_____ _____

List all MEDICATIONS & SUPPLEMENTS you are taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

	Age	*Asthma*	*Hayfever*	*Sinusitis*	*Eczema*	*Other:*	*Deceased (cause)*
Father							
Mother							
Brothers							
Sisters							
Children							

DO NOT WRITE IN THIS AREA

ENVIRONMENTAL HISTORY:

How long have you lived in this region of the country? _____

List Previous Residences: _____

List ALL ANIMALS at home & Access to Bedroom: _____

Note ALL SMOKERS at home: _____

Type of home:	Apartment	House	Dormitory	Other:
	Age of home: _			
Bedroom:	Bed:	Mattress	Waterbed	Age:
	Pillows:	Synthetic	Feather	Allergy cover
	Comforter:	Synthetic	Feather	Allergy Cover
	Flooring:	Carpet	Wood	Area Rug
		Stuffed Toys	Pets	
AC:	Central	Window	Humidifier	Dehumidifier
Heat:	Forced hot air	Electric	Gas	Wood burning stove
	Other: _____			
Basement:	None	Damp/Mold	History of Water Damage	

OCCUPATONAL HISTORY:

Current/ Previous Occupation(s): _____

Exposures at work: Chemicals Fumes Latex Other: _____

Are your symptoms worst at work? Yes/ No

Missed School or work because of your condition? _____

SOCIAL HISTORY:

Smoker?_____ Pack per day for_____years Quit? (Date) _____

Smoking Status Choices

1. Current every day smoker
2. Current some day smoker
3. Smoker, current status unknown
4. Never Smoker
5. Former Smoker
6. Unknown if ever smoked

Alcohol: Yes No **Quantity:** _____

Marital Status: _____

REVIEW OF SYSTEMS:

General Health Problems: _____ **NONE**

Eye Problems: _____ **NONE**

Heart Problems: _____ **NONE**

Gastrointestinal: _____ **NONE**

Kidney/Bladder: _____ **NONE**

SKIN: _____ **NONE**

BLOOD: _____ **NONE**

NEUROLOGICAL: _____ **NONE**

PSYCHIATRIC: _____ **NONE**

MUSCLE/JOINTS: _____ **NONE**

TO BE COMPLETED BY PHYSICIAN

Date *MD* *Date* *MD*

HISTORY AND EXAMINATION DETAILED COMPREHENSIVE

COMPLEXITY OF
MEDICAL DECISION MAKING COMPREHENSIVE HIGH

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Meaningful Use Demographic

Race Choices	Ethnicity Choices
American Indian	Hispanic Origin
Asian	Non-Hispanic Origin
Black	Unknown
Native Hawaiian	
Unknown	
White	

Language Choices

Arabic
Armenian
Chinese
English
French
French Creole
German
Greek
Gujarati
Hebrew
Hindi
Italian
Japanese
Korean
Persian
Polish
Portuguese
Russian
Spanish
Tagalog
Unknown
Urdu
Vietnamese
Yiddish