# Adult & Pediatric Allergist of Central Jersey

**1740 Oak Tree Road** **260 State Route 34**
**Edison, NJ 08820** **Matawan, NJ 07747**

## Patient Information (must be completed in full)

Patient Last Name:_____First:_____Sex (M) (F)
Address:_____City, State, Zip:_____
Home Telephone :( __)_____Work Telephone:( __)_____
Cell Phone: _____Birthdate:_____
Soc. Security #_____ Marital Status: (M) (D) (W) (S) Ethnic Origin:_____
Referred By:_____Email:_____Employer: _____
Pharmacy: _____ Pharmacy Phone: _____ Mail Order _____

## Responsible Party Information (must be completed in full)

Last Name:_____First Name_____Sex (M) (F)
Address:_____City, State, Zip _____
Home Telephone: ( )_____Work Telephone: ( )_____ _____
Birthdate:_____ _____Social Security #: _____
Employer: _____Occupation: _____

## Insurance Information (must be completed in full)

**Primary Ins._____Secondary Ins._____**
Name of Insured:_____Name of Insured:_____
ID#:_____ ID#:_____
Group #:_____Group #:_____
Address:_____Address:_____
City, State: _____ City, State:_____
Birthdate:_____Sex (M)(F) S.S.#_____Birthdate:_____Sex (M)(F) S.S.#_____
Zip Code:_____Zip Code:_____
Relationship to patient:_____ Relationship:_____
Employer: _____Employer:_____
Date of Employment: _____ Date of Employment: _____
Occupation: _____Occupation: _____

## Emergency Notification (must be completed in full)

Last Name:_____First Name:_____
Address:_____
City, State. _____Zip:_____
Telephone (__)_____Relationship:_____

## Release of Authorization/Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician. I agree to make payment as services are rendered. I understand that if for any reason my medical insurance does not make expected payment or if my insurance is terminated, I will be responsible for the total fee. In the event that my bill is sent to collection I will be responsible for the bill itself along with the collection fee.

_____/____/_____

**(Patient or Representative)** **Date**

# Adult & Pediatric Allergist of Central Jersey


Jayesh G. Kanuga, MD, FACAAI, FACA
Ligaya V. Centeno, MD, FACAAI
Ruby C. Reyes, MD, FACAAI
Diplomates American Board of Allergy & Immunology

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## Initial Visit

**Name:** **DOB:** **Age:** **Sex Male/ Female** **Date:**

Usual Physician: _____

Pharmacy Name/ Phone #: _____

Referred by: _____

Mail Order pharmacy name and #: _____

**ALL CURRENT MEDICINES Dose Frequency**

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

**PREVIOUS ALLERGY OR ASTHMA MEDICATIONS:**

_____ ☐helped ☐no help ☐Side Effects: _____
_____ ☐helped ☐ no help ☐ Side Effects: _____
_____ ☐helped ☐ no help ☐ Side Effects: _____

**Drug Allergies:** Symptoms:

_____Caused_____
_____Caused_____
_____Caused_____

**Other Allergies:**
☐Food:_____ ☐Venom_____
☐Latex_____ ☐ Other: _____

Immunizations up to date for the age: ☐ Yes ☐ No
Immunization Adverse Reactions: ☐ Yes ☐ No

Caused?:_____

Chronic Health Conditions: Age or Year

_____Since _____
_____Since _____
_____Since _____

**PAST MEDICAL HISTORY**

Hospitalizations: Age or Year

____ for _____
____ for _____
____ for _____

Surgeries:
____ for _____
____ for _____
____ for _____

Birth/childhood history:
Problems present at birth ☐Yes ☐No
If Yes, Explain:_____

Frequent illness as child ☐Yes ☐No
If Yes, Explain:_____

Prior Lab Results:
_____
_____

**To be completed by Nursing Staff:**

Height: _____ Weight: _____

B/P: _____ Pulse: _____

ACT score: _____

Patient's Name: _____

| **Family History** | Allergies | Asthma | Eczema | Sinus problems |
|---|---|---|---|---|
| Mother | □ | □ | □ | □ |
| Father | □ | □ | □ | □ |
| Brother(s) | □ | □ | □ | □ |
| Sister(s) | □ | □ | □ | □ |
| Maternal side | □ | □ | □ | □ |
| Paternal side | □ | □ | □ | □ |
| Family | □ | □ | □ | □ |
| Other: _____ | □ | □ | □ | □ |

List other chronic conditions
_____
_____
_____
_____

**Social History**

Smoking:
12 yrs old and up: Are you a smoker: □Yes □ No If yes, how many years?: ____ packs/day____
What do you smoke? □ Cigarettes □ Cigars □ Pipes □ Other _____
Have you ever tried to quit smoking? □ Yes □ No Method: _____

Have you ever smoked? □Yes □No When did you quit? ____yrs How many yrs did you smoke? _____yrs
Exposed to second hand smoke? □Yes □ No

**Under 12 yrs old:**
Exposed to second hand smoke? □Yes □ No

Use of Recreational Drugs? □Yes □ No
Smoked_____ Intranasal_____ Other_____

Drink Alcohol? □Yes □ No
Number of drinks per week_____ □daily □occasionally □rarely □socially
Other relevant social factors:_____
How often do you consume caffeine? product: _____ #/week_____

Marital Status: _____ Living Status: □alone □with family □with friend □nursing care □other
Any children? □Yes □No How many? _____
Current occupation is: _____
Occupational exposures: _____
Hobbies:_____

**CURRENT ENVIRONMENT:**

Check one: □House □Apartment □Mobile home □Farm □Other_____
# of yrs in present home? □less than one year □1-5 years □more than 5 years
How old is your home? _____ Yrs Live/Work near farm? _____ type_____

| | Yes/No | | Yes/No |
|---|---|---|---|
| Cats | □ □ Sleeps?: □inside | Baseboard Heat | □ □ heat type: □oil/gas □electric |
| Dogs | □ □ | Forced air heat | □ □ □coal □fireplace_gas |
| Birds | □outside□bedroom | Radiators | __wood |
| Other pets | □ □ | Air conditioning | □ □ |
| Feather pillows | □ □ | Ceiling fans | □ □ |
| Down comforter | □ □ | Humidifier | □ □ |
| Carpets or rugs | □ □ | Air filter | □ □ |
| Damp basement | □ □ | Stuffed animals | □ □ |
| Mold growth | □ □ | Bookcases | □ □ |
| | □ □ | Live house plants | □ □ |
| | □ □ | | □ □ |

Comment: _____
Name of person filling out this history form (please print): _____
Relationship if not the patient: _____

# *ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY*

*JAYESH G. KANUGA, M.D. FACAAI, FACA*
*LIGAYA V. CENTENO, M.D. FACAAI*
*RUBY C. REYES, M.D. FACAAI*
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## CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment, it may also be used for payment and operational purposes, I have the right to review the Adult and Pediatric Allergist of Central Jersey's "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practices. Changes in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment, or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special

Restriction:_____.

I understand that from time to time my physician and his/her staff may inform me of new drugs, treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me of such new drugs, treatments or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my medical record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Patients Name: _____ Date: _____
Signature: _____

# *ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY P.A.*

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## Communication Consent

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. The Administrative Simplification section of this act is of concern to our practice and requires us to comply with specific rules regarding:

- Unique identifiers for health plans, providers, individuals and employers.
- Healthcare transactions & code sets for transmitting electronic data.
- Privacy Regulations over discloser and use of health information.
- Security Regulations over protections of electronic health information.

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged matter.

It will be the policy of Adult & Pediatric Allergist not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, e-mail, cellular phone, pager and/or fax. Whenever returning telephone calls and an answering phone picks up, we will not leave a message if the name or telephone number is not on the recording to identify the residence. Information will not be left with an unauthorized person who may answer your telephone.

If you would like to have your medical information released to someone other than yourself, please complete the following:

I authorize Adult & Pediatric Allergist to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

| | | |
|---|---|---|
| Home Telephone | Yes | No |
| Answering Machine | Yes | No |
| Work Telephone | Yes | No |
| Voice Mail | Yes | No |
| Cellular Phone | Yes | No |
| Pager | Yes | No |

Please list authorizations:

| | | |
|---|---|---|
| Spouse/Fiancé: _____ | Yes | No |
| Parent: _____ | Yes | No |
| Brother/Sister: _____ | Yes | No |
| Son/Daughter: _____ | Yes | No |
| Friend: _____ | Yes | No |

Patient Name: _____

_____ _____
Patient/Guardian Signature Date

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Name: _____ Account #: _____DOB: _____ Date: _____

## Advance Directive

Do you have Advance Directive/Living Will? (For patients 18 and above).

Yes [ ] No [ ]

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## Cultural/Linguistic barriers to Care

Do you have any of the following? (Please circle)

Poor Vision Language Barrier

Poor Hearing Religious/Cultural barriers

None of the above

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## Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete this form before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of service. Payment may be made by cash, check, MasterCard, Visa or Discover. We will only bill insurance carriers with whom we participate.

Regarding Manage care insurance with which we participate: You are responsible to supply our staff with your primary and secondary insurance identification card(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to begin seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the service in full. If your insurance requires a co pay, it must be paid at the time of the appointment.

At times your insurance carrier will deny payment for authorized services. If so, you may be asked to help resolve these issues with your carrier.

Regarding Non-Participating Insurances**:** If one of our physicians do not participate, the bill is your responsibility. We accept cash, check, MasterCard, Visa and Discover. Your insurance policy is a contract between you and your insurance company.

Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you.

Medicare: We do participate with Medicare. This means that we will submit your claims to Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one, or to you. You will also be responsible for payment of your yearly deductible.

Return Checks Fee: $10.00**.** Our bank charges us a fee for any return check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs and their after payment must be made by cash, MasterCard, Visa or Discover.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. Accounts that go to collection will be subject to a 25% charge.

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at time of service, please let us know before you see the doctor that you would like to discuss a payment plan.

I have read the above Adult & Pediatric Allergist of Central Jersey, PA Financial policy. I understand and agree to abide by its terms.

_____ _____
Signature of Patient/Parent/ Guardian Date

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**Non-Covered Services Member Consent Form**

I understand that the services and/or supplies listed below may not be considered eligible for benefits by my health insurance company. Services may be determined to be a non-covered service or investigational by my insurance company. I understand that my health insurance company may have restrictions, limitations, or non-covered services. Since I have chosen to obtain the services listed below, I agree to be financially responsible for any and all related charges if they are not covered by my insurance company.

Non-covered services may need to be paid at the time of service. Possible examples of non-covered services include, but are not limited to, Flu Vaccine, pneumococcal vaccine, pulmonary function test or FeNO.

Adult & Pediatrics Allergist will file a claim on your behalf and you will be responsible for any non-covered services. The patient should understand that they are responsible for checking their benefits with their insurance carrier before their appointment time. The billing department can assist you with any questions you may have

_____ _____
Patients Name Date of birth

_____ _____
Legal Guardian or Member Signature Date

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# PRIVACY ACT

**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.**

**WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in [insert location where notice will be posted, e.g., main reception area]. You can also request a copy of this notice from the contact person listed in Section IV below at any time and can view a copy of this notice on our Web site at [insert Web site address if applicable].

## III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of uses and disclosures.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Require Your Written Prior Consent**.

We may use and disclose your PHI with your consent for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.
3. **For health care operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that You received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

**8. For workers' compensation purposes.** We may provide PHI in order to comply with workers compensation laws.

**9. Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

4. **Exceptions to consent requirements for treatment, payment, and health care operations.** Although your consent is required for numbers 1-3 of this section, above, we may disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment or we try to get your consent but your are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think you would consent if you were able to do so.

**B. Certain Uses and Disclosures Do Not Require Your Consent.**

We may use and disclose your PHI without your consent or authorization for the following reasons:

1. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial of administrative proceeding.
2. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.
3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.
5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.
6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
7. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

**C. Use and Disclosure Where You to Have the Opportunity to Object:**

**1. Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**D. All Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

**IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.**

You have the following rights with respect to your PHI:

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**B. The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you to an alternate address V. (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

**C. The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing, If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $ fee] for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

**D. The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations,

Signature: _____

Patients Name: _____

directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before (insert your organization's HIPAA compliance date).

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $[insert fee] for each additional request.

**E. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

**F. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

**V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.**

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., SW.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.**

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:

Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, NJ 08625-0367
Phone (800) 792-9770

State of New Jersey
Office of Ombudsman
CN 808
Trenton, NJ 08625
Phone (877)582-6995

**VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on October 1, 2001.

Amendment: August 21, 2012