Allergy, Asthma & Arthritis Associates, P.C.

Adult and Pediatric Allergy and Clinical Immunology

Stephanie Knapp, D.O., FACAAI American Board of Allergy and Clinical Immunology
Anil Patel, M.D., American Board of Allergy and Clinical Immunology

WELCOME! You or your child is scheduled as a new patient in our practice. The visit will last approximately 1 – 1 ½ hours. For efficiency reasons, we ask that you complete the new patient information and history forms prior to your appointment. Please bring the completed forms as well as your insurance card and driver's license for identification along with you to your appointment.

If your insurance requires a referral form, please contact your primary doctor. If you do not have a referral at the time of your visit, you will be asked to reschedule your appointment. **Please provide your primary doctor with the following information:**

Provider Name: Allergy, Asthma & Arthritis Associates

NPI# 1952364739

Also, please obtain copies of the results of any recent bloodwork or x-rays. Please bring a list of your current medications with you.

FOR ALLERGY PATIENTS ONLY: As a reminder, do not use antihistamines for **5 days prior to your visit** (if you are able), in order to have allergy testing performed. If you are not sure if you are currently on antihistamines check with your primary doctor or your pharmacist.

The Doylestown office is located across from Doylestown Hospital on Progress Drive. The sign in front of the office is "Doylestown Pointe 103". The Newtown office is located down the street from the Newtown Post office – across from Santander Bank.

If you have any questions, please do not hesitate to call our office at (215)345-6332 (Doylestown office) or (215)968-6000 (Newtown office). If you need to cancel your appointment, kindly give our office at least 24 hours notice to avoid being charged.

Thank you for your cooperation.

Stephanie Knapp, D.O.

Anil Patel, M.D.

www.allergyappointment.com

103 Progress Drive, Suite 100 Doylestown, Pa. 18901 (215)345-6332 Fax# (215)345-0302
4 Terry Drive, Suite 10 Newtown, Pa. 18940 (215)968-6000 Fax# (215)968-9287

APPT. DATE:________________ TIME:________________ DR:________________________

Allergy, Asthma, and Arthritis Associates, P.C.

❑ **Doylestown Office** • 215-345-6332
103 Progress Drive, Suite 100 • Doylestown, PA 18901

❑ **Newtown Office** • 215-968-6000
4 Terry Drive, Suite 10 • Newtown, PA 18940

PATIENT INFORMATION

TODAY'S DATE: ____________

NAME: ____ DATE OF BIRTH: ________________

ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP: __________

HOME PHONE#: (   ) __________ CELL PHONE#: (   ) __________ WORK PHONE#: (   ) __________

SEX: ______ MARITAL STATUS: __________ AGE: ______ SS#: ________________

MOTHER'S NAME: ______________________ FATHER'S NAME: ______________________

PRIMARY INSURANCE: ____

ADDRESS: ____

ID#: ____________________ GRP#: ______________ SS#: ________________

SUBSCRIBER'S NAME: ____________________________ DATE OF BIRTH: ________________

EMPLOYER'S NAME: ____

ADDRESS: ______________________________ PHONE#: (   ) ______________________

SECONDARY INSURANCE: ____

ADDRESS: ____

ID#: ____________________ GRP#: ______________ SS#: ________________

SUBSCRIBER'S NAME: ____________________________ DATE OF BIRTH: ________________

EMPLOYERS NAME: ____

ADDRESS: ______________________________ PHONE#: (   ) ________________

REFERRED BY: ____

PRIMARY PHYSICIAN: ____

ADDRESS: ______________________________ PHONE#: (   ) ________________

CITY: ______________________________ STATE: __________ ZIP: __________

ALLERGY, ASTHMA, & ARTHRITIS ASSOCIATES, P.C.

103 Progress Drive, Ste 100
Doylestown, Pa. 18901
(215)345-6332

4 Terry Drive, Suite 10
Newtown, Pa. 18940
(215)968-6000

FINANCIAL RESPONSIBILITY POLICY

In order to provide you with quality service we ask you to read and sign this form to acknowledge your understanding of your financial responsibility.

Allergy, Asthma, & Arthritis Associates, P.C. (AAAA) accepts Medicare, Aetna, Blue Cross/Blue Shield, Personal Choice, Independence Administrators and Most Commercial Insurance Plans. Services include office visits, diagnostic tests, challenges, injections and any other billable services performed or initiated by AAAA.

Please be aware that some of the services may not be covered by your insurance plan. It is our policy not to perform services unless deemed medically necessary.

You are required to provide us with your current and correct insurance information. If you have any changes in your insurance coverage, please notify us to prevent a claim denial. You will be responsible for any charges incurred if the information provided is not correct or updated. It is your responsibility to verify coverage of services and obtain referrals with your insurance plan. It is also your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations. This information is furnished by your insurance plan.

You are responsible for the payment of copays, coinsurance, deductibles and services not covered by insurance plan. Copays are due at the time of service.

I hereby authorize my insurance benefits be paid directly to Allergy, Asthma, & Arthritis Associates, P.C. I am financially responsible for the non-covered services. I authorize AAAA to release any information required, to my insurance company, for payment of services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that this information if true and correct to the best of my knowledge. I will notify AAAA of any changes in my health insurance.

________________________________ ________________
SIGNATURE DATE

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HIPAA AUTHORIZATION FORM

I, ______________________________(patient) acknowledge that I have received, been offered, or read on Allergy, Asthma & Arthritis Associates' (AAAA) website (www.allergyappointment.com) notice regarding privacy of personal health information.

I authorize AAAA regarding any test results, prescriptions or refills:

____ leave a message on my home phone #____________________

____ leave a message on my cell phone #______________________

____ if we can speak to someone other than the patient please list their names:

____

I authorize AAAA regarding any matters related to my care:

____ can only speak to me

____ can speak to the following people:

____

Date:___________ ______________________________
(Patient or Legal Guardian)

This consent has no expiration date. (updated 10/9/18)

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Notice Regarding Privacy of Personal Health Information

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) requires that the practice provide you with this notice regarding privacy of personal health information.

Protected Health Information

Protected health information is information created or received by your health care provider that contains facts that may be used to identify you. It includes information about your past, present, or future physical or mental health; the provision of health care to you, and payments for health care.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

We will use your health information for treatment.
For example: Your protected health information will be recorded in your record and may be used to coordinate your health care with a third party. It may be disclosed to a pharmacy to fill a prescription, to an X-ray facility to order an X-ray, to other physicians in order to administer your allergy shots, or to other physicians or health care providers for treatment activities of those providers.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may identify you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff or the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

We may use your protected health information to remind you of an appointment, inform you of treatment options, and inform you of health-related services that may be of interest to you.

We may also disclose your protected health information under the following circumstances without your permission or authorization:

1) When legally required
2) When there are risks to public health
3) When there is evidence of possible abuse, neglect, or domestic violence.

4) To conduct health oversight activities such as audits, investigations, or proceedings, inspections, or licensure or disciplinary actions. However, if you are the subject of an investigation, the practice will not disclose protected health information that is not directly related to your health care.
5) For law enforcement purposes such as required by law or in response to a valid subpoena
6) To coroners, funeral directors, and for organ donation
7) For research purposes if approved by an institutional review board or privacy board that has examined the research proposal and the research protocols which maintain the privacy of your protected health information
8) To the Food and Drug Administration (FDA) when an adverse event occurs with respect to a food, supplement, or drug.
9) For workers compensation or similar programs in order to comply with their laws
10) For communication: using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Other than the circumstances described above, the practice will not disclose your health information unless you provide written authorization. You may revoke your authorization in writing at any time except to the extent that the practice has taken action in reliance upon the authorization.

Your Rights

Under the HIPAA privacy regulations, you have certain rights regarding your protected health information.

1) The right to inspect and copy your protected health information in a designated record set. This includes medical and billing records. The practice may deny your request if the practice determine that access requested is likely to endanger the life or safety of you or another. You may request a review of this decision.

You may not inspect or copy certain records by law, including information compiled in anticipation of or for use in a civil, criminal, or other action or proceeding and protected health information that is subject to a law that prohibits access to protected health information.

You must submit a written request to the practice in order to inspect and copy your health information. You may be charged a fee for the costs associated with complying to your request.

2) The right to request restrictions on uses and disclosures of your protected health information is not made available to others, including family members or friends. Certain disclosures and uses of patient information require authorization from the patient. These disclosures include: psychotherapy notes, information used for marketing or fundraising and restricting information release.

3) The right to request to receive confidential communications from the practice by alternative means or locations. You may request that the practice communicate with you through alternative means or locations. We will make every effort to comply with reasonable requests. The request should be made in writing to the practice.

4) The right to request an amendment of your health protected health information.

You have the right to request an amendment of the information in your records. This request must be made in writing to the practice and should supply a reason to support the amendment. The practice may deny your request. You in turn, may file a statement of disagreement with the practice.

5) The right to request that the office does not disclose any information about our services to an insurance company when you have paid for a service in full and out of pocket.

6) The right to be notified in writing when a breach in your protected information occurs. That means any breach – no matter how minor – has to be reported to the patient and also covered in the office's year-end HIPPA report.

7) The right to request an accounting of certain disclosures. You have the right to request an accounting of the practice's disclosures of your protected health information made for purposes other than treatment, payment, or health care operations as described in this notice. The request should be made in writing to the practice and should state the time period for which you wish the accounting to include. The practice is not required to provide an accounting for disclosures prior to April 14, 2003.

Our Responsibilities

This practice is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

Complaints

If you believe your privacy rights have been violated, you can file a complaint in writing with the practice. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

This notice is effective on April 14, 2003.

UPDATED 7/2/2013