

FIRST COAST ALLERGY AND ASTHMA
SANJAY SWAMI, MD

Patient Information: This section refers to the PATIENT ONLY

Social Security Number: _____	If Employed, Company: _____
Last Name: _____	
First Name: _____ MI _____	Occupation: _____
Nickname / Title: _____	Address: _____
Address: _____	_____
Zip Code: _____ City: _____ State: _____	Zip Code: _____
Home Phone: (_____) _____	City/State: _____
Work Phone: (_____) _____ Ext _____	Marital Status: _____
Birth Date (mm/dd/yyyy): _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	If Student: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Medical Chart Number: _____	Name of School: _____
E-mail address _____	

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: <input type="checkbox"/> Self(skip to next section) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Employer <input type="checkbox"/> Other: _____	
Social Security Number: _____	If Employed, Company: _____
Last Name: _____ Jr., II, _____	_____
First Name: _____ MI _____	Address: _____
Nickname / Title: _____	_____
Address: _____	_____
Zip Code: _____ City: _____ State: _____	Zip Code: _____
Home Phone: (_____) _____	City/State: _____
Work Phone: (_____) _____ Ext _____	Marital Status: _____
Birth Date (mm/dd/yyyy): _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED

Relationship to Patient: <input type="checkbox"/> Self(skip to page 2) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	
Social Security Number: _____	If Employed, Employer: _____
Last Name: _____ Jr., II, _____	_____
First Name: _____ MI _____	Address: _____
Nickname / Title: _____	_____
Address: _____	_____
Zip Code: _____ City: _____ State: _____	Zip Code: _____
Home Phone: (_____) _____	City/State: _____
Work Phone: (_____) _____ Ext _____	Marital Status: _____
Birth Date (mm/dd/yyyy): _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Please ensure the office has a copy of your most recent insurance card(s)

Please ensure the office has a copy of your current Drivers License

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s).

PRIMARY INSURANCE COVERAGE:

Insured (Name on card) _____ Insured ID Number _____
Insurance Co. Name: _____ Group/Member/Policy Number _____
Address: _____ Effective Date: _____

SECONDARY INSURANCE COVERAGE:

Insured (Name on card) _____ Insured ID Number _____
Insurance Co. Name: _____ Group/Member/Policy Number _____
Address: _____ Effective Date: _____

THIRD INSURANCE COVERAGE:

Insured (Name on card) _____ Insured ID Number _____
Insurance Co. Name: _____ Group/Member/Policy Number _____
Address: _____ Effective Date: _____

IN CASE OF EMERGENCY . . .

Name and Phone number of nearest relative (include relationship):

Name and Phone Relationship

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN . . .

I hereby authorize the office of B111-DBA Baptist Physician Partners, to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

Date Signature of Patient and / or Guardian, if patient is Minor

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to B111-DBA Baptist Physician Partners, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date Signature of Patient and / or Guardian, if patient is Minor

How were you referred to the practice . . .

- Dr. _____ Friend/Relative Radio Newspaper
 Other: _____



Sanjay Swami, MD
Board Certified Allergist

FINANCIAL POLICY/FACILITY POLICY

Thank you for choosing First Coast Allergy and Asthma as your healthcare provider. We are committed to providing the best medical care possible. We hope that you will leave our office with an appreciation for the value of the services you have received. Please understand that payment of your bill is considered a part of your treatment. Accordingly, we ask all of our patients to pay for their services at the time the services are rendered. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment. A copy will be provided to you upon request.

All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.

All applicable co-pays, personal balances, both current and prior, are due at time of service.

We accept cash, check, Visa, Master Card, American Express, and Discover.

Regarding Insurance

We participate with most insurance plans, including Medicare. For some other insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by insurance. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, it may take some time to obtain verification of your coverage. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You must pay for these services in full at the time of visit.

The introduction of high deductible policies has made it difficult to estimate all charges at the time of your visit. We now have available Electronic Drafts or Credit Card on Account Options. You simply execute an authorization form and the payment for your services received at our office will be drafted from your checking account or billed directly to your credit card. We will not be able to accept debit cards when utilizing this option. For those of you desiring payment programs, a series of drafts can be arranged.

By offering this new payment service, we help you avoid the time and hassle involved in receiving statements and issuing checks to settle your account. Please inquire at our front desk about how you can establish and Electronic Draft or Credit Card on Account program with our office.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

Missed Appointments/ No Show Policy

Unless canceled at least 24 hours in advance, our policy is to charge \$25.00 for a missed appointment. Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance so it will be your personal responsibility.

Past Due Accounts

Accounts are considered past due after 90 days. Patients who are sent additional statements will have a statement handling fee of \$15 charged to each statement. Overdue accounts will be referred to a collection agency along with the issuance of a 1099 to the IRS for cancellation of a debt. Fees that we pay to secure past due balances will be added to your account. Once an account has been referred to collections, First Coast Allergy and Asthma will terminate the patient relationship and only continue services for thirty days (30) for emergencies and only on a cash basis.

Co-Payments and Deductibles

All co-pays and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If co-pay balances are not paid on date of service a \$10.00 fee will be charged to your account. This fee is *not* covered by insurance so it will be your personal responsibility.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a \$30.00 fee. Our policy is that once a check has been returned further services must be paid using credit card, money order, or cash.

Medication Refills

Prescription medication is vital to maintaining proper physical and mental well-being of our patients. In all possibilities, provide us time by contacting your established pharmacy and have them fax the request to our office within 3-5 days prior to running out of any medications. Refills called into the office take 24 hours to process. This will assist us in better serving you and attending to those requiring assistance with their scheduled appointments or medial emergency.

Routine Medications

Prescriptions will be re-written every six (6) months with a follow-up appointment. This will assist with proper health maintenance issues and control of any chronic condition.

Medical Records

All of our patient records and x-rays are kept confidential. By law, we are required to keep the original medical records and x-rays in our possession for seven years. Copies may be furnished to you when you request them in writing with exception to state law. Our policy requires 48 hours advance notice for preparation of copies, as well as, prepayment for those copies. Our charge is in accordance with Florida law Chapter 64B8-10, Medical Records Retention, Disposition & Reproduction, Statute 64B8-10.003 which state the following:

- A. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records:
- B. Reasonable cost of reproducing copies of written or typed documents or reports shall not be more than the following
 - (1) For the first 20 pages, the cost shall be \$1.00 per page. For each page in excess of 20 pages, the cost shall be \$0.25 cents each.
- C. Reasonable cost for reproducing x-rays and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the materials & supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

For further information about the law stated above, please contact the Florida Board of Medicine at (850) 488-0595.

Consent for Medical Treatment

I am the patient or the patients duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatment regimens necessary in the judgment of my provider, for myself, my minor child, or other. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as a result of treatments or performed examinations.

I have read this form completely, have had the opportunity to ask questions, and have been fully informed as to the contents of this agreement.

I do hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to First Coast Allergy and Asthma.

Signature of patient or responsible party

Witness Signature

Date

Notice of Privacy Practices
FIRST COAST ALLERGY AND ASTHMA

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.

If you have any questions about this Notice please contact our Privacy Official.

At First Coast Allergy and Asthma, we are committed to protecting and preserving your privacy. We understand that health information about you is personal and that you are concerned over how it is used. This Notice of Privacy Practices describes:

- how the health care professionals, staff, employees, students, trainees, volunteers and certain associates of First Coast Allergy and Asthma may use and disclose your protected health information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law; and
- your rights to access and control your protected health information.

"Protected health information" is information about you that relates to your past, present or future physical or mental health or condition and related health care services, and that includes demographic information that may identify you. The terms of this Notice apply to all records containing your protected health information that are created or retained by our practice.

We are required by federal law to maintain the privacy of your protected health information, as described in this notice. We are also required to provide you with and abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice of Privacy Practices at any time, and the new Notice of Privacy Practices will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. We will at all times keep a copy of the most current version of this Notice posted in a visible location in our offices.

I. HOW FIRST COAST ALLERGY AND ASTHMA USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION

A. Permitted Uses and Disclosures of Protected Health Information:

Once FIRST COAST ALLERGY AND ASTHMA has provided you with this Notice, and you have had the chance to acknowledge that you have received it, First Coast Allergy and Asthma may use or disclose your protected health information as described in this Section I. 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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 use or disclose, as-needed, your protected health information in order to support the business activities of First Coast Allergy and Asthma. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, certain limited marketing activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school 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 your 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 will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Health-Related Benefits and Services/ Treatment Options: We may use and disclose protected health information about you to inform you of other health-related services or benefits offered by our practice or an affiliated organization that may be of interest to you, or to provide you with information about potential treatment options or alternatives that may be of interest to you. We may also use and disclose your protected health information for other limited marketing activities - for example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. *You may contact our Privacy Official to request that these materials not be sent to you.*

Fundraising Activities: We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. *If you do not want to receive these materials, please contact our Privacy Official and request that these fundraising materials not be sent to you.*

Appointment Reminders: We may use and disclose your protected health information, as necessary, in contacting and reminding you of your upcoming appointment(s).

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or First Coast Allergy and Asthma has taken an action in reliance on the use or disclosure indicated in the authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family, Friends and Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to provide you with this Notice as soon as reasonably practicable after the delivery of treatment. If your physician or another physician within First Coast Allergy and Asthma is required by law to treat you and the physician has attempted to provide you with this Notice but is unable to do so, he or she may still use or disclose your protected health information to treat you.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization or opportunity to object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may use and disclose your protected health information for research purposes in certain limited circumstances. We will obtain your written authorization to use your protected health information for research purposes, except when the Internal Review Board or Privacy Board has determined that a waiver of your authorization meets certain criteria to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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 et. seq.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and First Coast Allergy and Asthma uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Our Practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Please contact our Privacy Official if you have questions about access to your medical records.

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 purposes 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. First Coast Allergy and Asthma is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If First Coast Allergy and Asthma does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment or it is required by law. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by putting your request in writing, including a detailed description of your requested restriction, and presenting it to our Privacy Official and to your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Official.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 any such rebuttal. Please contact our Privacy Official to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. However, there are certain disclosures that we are not required to, and will not, include in such accounting, including disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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 electronically.

3. 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 our Privacy Official of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Official, at 123/456-7890 for further information about the complaint process.

This notice was published and became effective on April 14, 2003.

FIRST COAST ALLERGY AND ASTHMA

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of FIRST COAST ALLERGY AND ASTHMA Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA") that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Patient's Name

Patient's Signature

Date

IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT, COMPLETE THIS SECTION:

____ Patient refuses to sign Acknowledgement. FIRST COAST ALLERGY AND ASTHMA made the following efforts to attempt to obtain a signature from the patient:

Signature of Practice Employee

Signature of Chief Privacy Official

NAME _____

DATE _____

Please complete the following questions as completely as possible if you have chronic nasal symptoms or breathing difficulty. **If not, please skip this section.**

SECTION ONE

Have you been diagnosed with asthma? Allergic rhinitis? Eczema?

Please circle symptoms you have experienced.

sneezing runny nose nasal stuffiness drip in throat throat clearing cough
sore throat itchy eyes watery eyes itchy nose itchy ears ear fullness itchy throat

How long have you had these symptoms?

Are your symptoms present throughout the year?

Are your symptoms worse during the spring, summer, fall, or winter?

Are your symptoms worse upon awakening, at night, or during the day?

Please circle any triggers for your symptoms.

trees grasses weeds dust cats dogs mold perfume cigarette smoke
changes in weather being indoors being outdoors

Please circle any medications you have tried. Place a check by the ones that have helped.

Claritin Allegra Clarinex Zyrtec Xyzal Benadryl Flonase Nasonex Rhinocort
Nasacort Veramyst Omnaris Beconase Astelin Astepro Patanase Singulair Atrovent
Afrin Patanol Pataday Optivar Zaditor Sudafed Tylenol Cold and Sinus
Advil Cold and Sinus Guaifenesin (Mucinex)

Have you ever had allergy testing? If so, what were you allergic to?

Have you ever had allergy shots and for how long? Did the shots help?

Please describe any reactions, if any, to your prior allergy shots.

Please circle symptoms you have experienced.

shortness of breath chest tightness wheezing cough waking up at night short of breath
easily tired or coughs with exercise

How long have you had these symptoms?

Are your symptoms present throughout the year?

Are your symptoms worse during the spring, summer, fall, or winter?

How often do you have these symptoms during the daytime?

_____ days each week daily rarely

How often do you have these symptoms at night? _____ nights each week rarely

Please circle any triggers for your symptoms.

trees grasses weeds dust cats dogs mold perfume cigarette smoke
changes in weather exercise cold weather colds or sinus infections

How many times have you been in the emergency room for difficulty breathing?

Last emergency room visit was _____

How many times have you been prescribed steroids by mouth or given a steroid shot for difficulty breathing? Last time _____

When was your last chest X – ray?

Last breathing test?

Please circle any medications you have tried and place a check (✓) by the ones that have helped.
albuterol or Xopenex - Over the past month, how many times did you use albuterol?
Advair Diskus – strength (/ 50) Advair HFA - strength (/21)
Symbicort - strength (/4.5) Asmanex Flovent Pulmicort Azmacort
QVAR Alvesco Singulair

SECTION TWO

Have you been diagnosed with reflux?

How often do you now have heartburn?

How many times each year do you have sinus infections?

When was your last sinus infection?

Please circle your typical symptoms during a sinus infection:

colored nasal discharge dry cough cough productive of yellow or green mucus tenderness
around eyes / over forehead / along bridge of nose

How many times have you been given antibiotics over the past year for sinus infections?

Please circle the antibiotics you have been prescribed:

Augmentin Amoxicillin Omnicef Z-pack Biaxin Levaquin Avelox Other _____

How many days are you usually prescribed antibiotics? 5 7-10 14 21

Do your symptoms resolve with antibiotics (please circle)? Yes No

When was your last sinus CT scan?

What did it reveal?

Have you had any reactions to the following? If so, please provide details.

Medications

Foods

Insect bites / stings

Rubber products

Please list below any other health conditions or surgeries.

Please list your medications.

Has anyone in your immediate family (parents, brother, sister, kids) been diagnosed with allergic rhinitis, asthma, or eczema?

If so, tell us which family member(s) have these conditions.

SOCIAL / ENVIRONMENTAL HISTORY

Pets: Dogs (how many? ___) Cats (how many? ___) Other pets: _____ (how many? ___)

Location of pets: inside outside sleep in bedroom

Is your bedroom carpeted? Yes No

Do you have any mold or water damage in your home? Yes No If yes, where?

Do you see standing water (e.g. puddles) frequent in your yard?

Do you live near a river, pond, or marsh? Yes No If yes, please specify. _____

Please list any particular trees in your yard or neighborhood.

Do you smoke tobacco? Yes No If yes, how many packs do you smoke daily? ___

How long? ___ years

Have you ever smoked? Yes No If yes, when did you stop smoking? _____ (year)

How many packs did you smoke daily? _____ How long? ___ years

Does anyone smoke inside your home? Yes No

What type of work do you do (for adults)? _____

Is something at work making your symptoms worse? Yes No

If yes, please tell us. _____

If your young child is being seen today, could you tell us if he/she attends daycare or school? Yes No

Do you have an air cleaner in your home? HEPA Ionizer or electrostatic device

Where is it located?

REVIEW OF SYSTEMS

Please circle if you have experienced any of the following.

- General:** Excessive fatigue, unexplained weight loss, loss of appetite, difficulty sleeping, unexplained fever
- Skin:** Recurrent rash, moles that have changed in size, shape, or color, patchy hair loss, persistent itching, dry skin
- GI:** Ulcers, frequent indigestion, frequent nausea and vomiting, frequent heartburn, black or bloody stools, frequent diarrhea, gallbladder disease, liver disease
- Heart:** Heart attack, chest pains, palpitations, heart murmur, ankle swelling, difficulty with exertion
- Eyes / ENT:** Loss of hearing, prolonged roaring or ringing in the ears, disturbance of vision, hoarseness, difficulty swallowing, glaucoma or cataracts, frequent eye irritation, significant dental problems, nasal polyps, chronic sinus infection
- Urinary:** Difficult or painful urination, frequent night urination, recurrent bladder or kidney infections, kidney stones, prostate trouble (men), venereal disease
- GYN:** Unusual or excessive vaginal discharge, use birth control pills, last period was _____, irregular pap smear
- Rheum:** Hot, swollen or painful joints, gout, bursitis, frequent back pain, fracture or injury
- Nervous:** Frequent or severe headaches, unexplained dizziness or vertigo, loss of consciousness, head injury, loss of feeling, seizures or tremors, stroke
- Psychiatric:** Frequent anxiety or tension, unexplained changes in mood, prolonged periods of feeling depressed, difficulty concentrating, personal problems that cause great concern, have you had psychiatric help?

PLEASE ANSWER THE FOLLOWING IF YOU HAVE BEEN DIAGNOSED WITH ECZEMA OR OFTEN HAVE RED, DRY, AND ITCHY SKIN. IF NOT, PLEASE SKIP THIS PAGE.

How long have you had eczema? From birth Began ____ years ago Never been diagnosed

What areas of your body are affected?

face neck elbows knees back stomach arms legs other _____

What soap do you use? _____ Do you use a moisturizer? Yes No

Do you apply the moisturizer immediately after bathing? Yes No

What type of moisturizer? Aveeno Eucerin Aquaphor Vanicream Other _____

How often do you use the moisturizer? Once daily Twice daily Once in a while

Do you use a steroid cream or ointment? Yes No Please name it. _____

How often do you use it? once daily twice daily once in a while

Which medications have you tried? Claritin Zyrtec Allegra Clarinex Xyzal Benadryl

Hydrocortisone Triamcinolone Betamethasone Protopic Elidel

Which of these medications seemed to help? _____

What seems to make the eczema worse? dust cats dogs foods other _____

Do any foods seem to make the eczema worse? milk eggs soy wheat fish peanuts tree nuts

Have you ever had a reaction to a food? Yes No

If so, please describe these reaction(s).

Do you currently avoid any foods? Yes No

Please circle those foods which you or (if your child is being seen today, your child) avoid or have never tried

Milk eggs soy wheat fish peanuts tree nuts (walnuts, pecans, cashews, etc.) shellfish

None Other (please name) _____

After birth, what type of feeding was given? Breastfed Bottle-fed (formula name _____)

When was the switch made to cow's milk? _____ months Never

What foods do you normally eat? _____

PLEASE ANSWER THE FOLLOWING IF YOU HAVE BEEN DIAGNOSED WITH HIVES OR HAVE UNEXPLAINED RASHES OR SWELLING. IF NOT, PLEASE SKIP THIS PAGE.

How long have you had these skin lesions? ____ weeks OR ____ months OR ____ years

Please circle the appropriate answer.

I have these lesions: everyday once every week once every month other _____

Are these lesions itchy? Yes No Are these lesions associated with burning? Yes No

Are these lesions raised? Yes No Have you had these lesions before? Yes No

How long does it take for a lesion on a part of your body (chest for instance) to resolve?

____ hours OR ____ days OR ____ weeks OR never went away

When the lesion finally goes away, is a scar left behind? Yes No

What shape are these lesions? Round Line-shaped Other, please describe _____

How big can the lesions get? Dime-sized Quarter-sized Larger than a quarter

List which parts of your body have been affected by these lesions. If present over your entire body, write "all over." _____

Please check (✓) if you have had swelling of your _____ lips _____ throat _____ eyes

Did you experience any shortness of breath? Yes No

What do you suspect may have caused the hives? _____

Have you taken any new medications recently? Yes No Please name them. _____

Do you currently take aspirin, ibuprofen (Advil, Motrin), or naproxen sodium (Aleve)? Yes No

If so, how often? _____

Have you tried any new soaps or laundry detergents? Yes No If yes, please name them. _____

Please name the soaps or laundry detergents you are currently using. _____

Have you traveled outside of the country recently? Yes No

Has anyone at home or work had similar rashes and swelling? Yes No

Have you taken any over the counter or prescription medications to help treat your rash? Yes No

If yes, please circle the medications below.

Claritin Allegra Zyrtec Clarinex Xyzal Hydroxyzine (Atarax) Benadryl

Prednisone Medrol Steroid injection Doxepin

Which of these medications seemed to help? _____

Dr. Swami strives to take care of all concerns in one office visit, however, due to the complexity of some conditions/symptoms which may require an extensive evaluation, we ask that you list the 2 most concerning problems to discuss with him in order of priority.

1. _____

2. _____
