SOUTH JERSEY ALLERGY & ASTHMA ASSOCIATES, P.A.

Adult & Pediatric Allergy, Asthma & Clinical Immunology

Linda M. Graziano, MD

• *Diplomate of the American Board of Allergy & Immunology*
• *Diplomate of the American Board of Internal Medicine*

Appt. Date: _____

Dear

Thank you for choosing South Jersey Allergy and Asthma. I am trained and board certified in both pediatric and adult allergy, asthma and clinical immunology. I anticipate making your health care visit a rewarding one. In order that we may partner better; up to an hour and a half has been allotted for your doctor visit and we have enclosed healthcare forms for you to complete prior to your appointment. **Please bring these *completed* forms to the initial visit, as any information on hand will be helpful. We do require that you arrive 20 minutes prior to your appointment so we may process this paperwork for your appointment. We will need your insurance cards, referral if necessary, and any copayment due at the time of the visit.**

Please remember to discontinue any antihistamines at least seven days prior to your visit and any *over the counter* sleep aids three days prior to your visit so we may test you at the time of your visit. However, if you have a rash or hives you may continue with your antihistamines and we can test you at a later time if needs be. It would be advised to wear a short sleeved shirt since we need to access your arms. We also ask that you refrain from wearing any perfume or cologne to the office as this may cause reactions in some of our patients.

If for any reason you are unable to keep this initial appointment, we require a 48 hour notice for all cancellations. This is so we can give another patient your slot since a significant amount of time has been set aside for your appointment. ***You will receive an appointment confirmation call which will require you to call our office to confirm your appointment***. We hope you find your experience with our office a pleasurable one whereby you have significant input into achieving your goals of better health.

We look forward to meeting you.

Sincerely yours,

Linda Graziano, M.D.

108 Kings Highway South, Cherry Hill, NJ 08034-2504 Ph: (856) 428-5120 Fax: (856) 428-0264

Patient Information

Date:_____

Name:_____ **Sex:** M_____ F_____

Address:_____ **Age:** _____

City:_____ **Date of Birth:** _____

State: _____ **Zip:**_____ **Social Security#:** _____

Home #: _____ **Occupation:**_____

Cell#: _____ **Work#:**_____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____ Student _____

If you would like to have access to your medical records, please provide your Email address below:
E Mail: _____

Family Physician: _____

Address: _____

Telephone #: _____

Pharmacy Name: _____ **Telephone#:** _____

Location: _____

Insurance Information (Primary Holder):

Subscriber's Name: _____ **Date of Birth:** _____

Address: _____ **Social Security #:**_____

City: _____ **State:** _____ **Zip:** _____

Relationship to patient: _____

Name of spouse of parent: _____

I authorize the release of any medical information necessary to process all claims. I authorize payment of medical benefits to South Jersey Allergy & Asthma Assoc. for services rendered. I also understand that my signature may be used as a "signature on file" for insurance purposes.

It is your responsibility to know, understand, and comply with the terms of your insurance contract. In the event your health plan determines a service to be "not covered", or payment is denied due to failure to comply (ex: no referral, pre-existing condition, limited allowance, etc.), you will be responsible for the complete charge. *Call your health plan if you have any questions regarding coverage.

Signature of Patient/Parent/Guardian: _____

(For all services rendered to a minor or disabled patient, we will look to the guardian for payment.)

Describe patient's typical symptoms:_____

_____

_____

SYMPTOMS (Circle all that apply)

Chest	Nose	Eyes	Throat	Skin	Ears
asthma	hay fever	itching	itching	itching	itching
cough	congestion	tearing	hoarseness	hives	blockage
wheeze	sneezing	swelling	voice loss	eczema	frequent infections
excess mucus	running	redness	frequent infections	infections	discharge
tightness	bleeding	styes	postnasal drip	swelling	hearing loss
shortness of breath	polyps	mattering	soreness		earaches
frequent infections	loss of smell		bad breath		
congestion	sinus infections		dryness		

Symptoms (circle) Year-round Seasonal Worst month _____ Best month_____

When do symptoms occur? (circle) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Which of the following appear to cause the allergy or asthma symptoms? (check)

POLLEN: trees_____ grass_____ weeds_____

ANIMAL HAIR DANDER: cats_____ dogs_____ horse_____ other furry pets or birds_____

ODORS: Christmas trees_____ detergents_____ soaps_____ hair sprays_____ paint fumes_____

tobacco smoke_____ cosmetics and perfume_____

OTHERS: temperature change_____ air conditioning_____ exercise_____ excitement_____ fatigue_____

spicy food_____ house dust_____ nighttime_____ rubber products_____ infections (colds)_____

stress_____ laughing_____ menses (periods)_____ dampness_____ aspirin_____ windy days_____

Work exposures (fumes? odors?) Include names of chemicals _____

How much school or work has been missed in the past year because of allergies or asthma?_____

Has a change in locale affected your symptoms? _____ If yes, how? _____

_____

PREVIOUS ALLERGY STUDIES:

Have skin tests been done before? _____ Have allergy blood tests been done? _____

Doctor _____ Date _____

Results _____ Allergy shots? _____ When? _____

When was the last chest x-ray? _____ Sinus x-ray? _____

MEDICATIONS: List every medication now being used (including non-allergy, non-asthma medications):

Drug	Frequency	Drug	Frequency
_____		_____	
_____		_____	
_____		_____	
_____		_____	

What medications have been helpful for asthma or allergies in the past? _____

_____

Has patient used Cortisone, Prednisone, Kenalog, Decadron, or other steroids? (list): _____

_____

MEDICATION ALLERGY: (aspirin, antibiotics, pain medicine, etc.) List drugs, reactions they cause and dates reactions occurred: _____

_____

INSECT STING ALLERGY: List specific insect and type of reaction. _____

_____

FOOD ALLERGY: List specific foods and describe reaction. _____

_____

ENVIRONMENTAL CONDITIONS:

Hobbies: _____ Occupation: _____

Age of house_____ Type of construction _____ Years at present address_____

Heating system: (check)

a. Gas_____ oil_____ electric_____ coal_____ other_____

b. Air conditioning? Yes_____ No_____ Type _____

c. Air filtering system? Central_____ room_____ none_____

d. Humidifiers? Central_____ room_____ none_____

f. Fireplace? Gas_____ Wood_____ None_____

(Please see next page)

Are there feather pillows? _____ (If yes, list where) _____

Is the basement wet, or do you see or smell mildew in the house? Yes_____ No_____

Which pets do you own? (check) dog_____ cat_____ bird_____ other _____

Are there farm animals near your home? _____ What kind? _____

Neighborhood contains: (name type if known) Trees_____

Fields_____ Farms_____

HEALTH HABITS:

a. Smoke tobacco? Yes_____ No_____ Daily amount _____ For how many years?_____

b. Do others smoke in the home? Yes_____ No_____

MEDICAL HISTORY (check all that apply):

Has patient ever had tuberculosis or a positive TB skin test____ ulcers____ diabetes____ high blood pressure____

glaucoma____ heart disease____ cataracts____ cancer ____ emphysema ____ nasal polyps____ chicken pox____

contact lens wearer_____ heartburn_____ urinary retention_____ other diseases_____

_____

HOSPITALIZATIONS, OPERATIONS, AND EMERGENCY ROOM VISITS:

Date Reason

_____

_____

_____

FAMILY HISTORY: If you know of allergies in any of your relatives, place check marks in the table below to show which relatives were affected by the conditions listed.

	Sisters/Brothers	Mother	Father	Children
Hay fever or other nasal allergy				
Asthma				
Eczema				
Hives				

Is there a family history of any other disease or condition? List: _____

_____

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I, _____; do understand that South Jersey Allergy & Asthma Assoc. require a copy of my credit card to be kept on file. This credit card will not be charged unless I have a delinquent balance on my account of 60 days or more. This balance would be due to charges my insurance company did not cover for any of the following:

1) Applied towards a deductible
2) Not a covered service
3) Portion of a Co-insurance that the Patient is responsible to pay
4) No Active Referral on file at time of service (including prepared allergy extracts)

South Jersey Allergy & Asthma Assoc. will keep all credit card information in a secure location, and will only charge monies owed from delinquent accounts.

By signing this form below, I am acknowledging and giving my consent for South Jersey Allergy & Asthma Assoc. to charge my credit card for delinquent balances that are owed on my account.

_____

Signature

_____

Date

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Consent and Acknowledgement Form

I hear by give my consent for South Jersey Allergy and Asthma Associates (SJAAA) to use and disclose personal health information (PHI) about me to carry out treatment, payments, and health care operations (TPO). SJAAA may release PHI pertinent to my case whether by standard mail, verbal communications, or facsimile, to any insurance company, adjuster, attorney, or other health care providers. I also consent that SJAAA may contact me by calling my home or alternate number; and if need be leave a message on voice-mail in reference to any items assisting in carrying out TPO. SJAAA may mail to my house or alternate location, items that assist in carrying out TPO such as appointment reminders and patient statements.

I also agree, in order for SJAAA to service my account or collect monies I may owe, SJAAA and /or their agents may contact me (by any means, including text messages) by any phone number associated with my account (including cell) which could result in charges to you. They may also send E-mails to the email address I have provided. (Methods of contact may include the use of pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.)

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior request. If I do not sign this consent or later revoke it, SJAAA may decline to provide treatment to me.

_____

Signature of Patient, Parent, or Legal Guardian

_____ _____

Patient's Name Date

Acknowledgement/ Receipt of notice of Privacy Practices

I acknowledge that SJAAA has posted and given me a copy of their "Notice of Privacy Practices".

_____

Signature of Patient, Parent, or Legal Guardian

_____ _____

Patient's Name Date

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I, _____, give permission for my medical findings and/or information regarding my account to be shared with (aside from your family doctor):

Name: _____

Relationship: _____

Phone Number: _____

_____

Signature of patient

_____

Date

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Medication List

Medication & Strength	Dose/How Taken How Often	Reason Used Diagnoses

SOUTH JERSEY ALLERGY AND ASTHMA ASSOCIATES'

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003

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 to carry out treatment, payment, management of health care operations, and other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition, and related health care services.

1. Uses and Disclosure of Protected Health Information

You will be asked by your physician to sign a consent form. Your PHI may then 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 purposes of providing health care services to you, to pay your health care bills, and to support the operation of the physician's practice. The following categories describe the different ways in which we may use and disclose your PHI.

Treatment: This section will give some examples of how we may use or disclose you PHI for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you. Some examples are:

- During your visit or as a result of your visit, our physicians and other staff members involved in your care may review and discuss your medical record and information.
- We may discuss your medical information with an outside physician to whom we have referred you for care.
- We may discuss your medical information with an outside physician with whom we are consulting for your care.
- We may share your information with an outside laboratory, radiology center, or other ancillary provider.
- We may share your information with a hospital.
- We will send reportable health information to the Department of Health, as required by law.
- We may use sign-in sheets in the waiting room.
- We may announce your name when it is time for your visit.
- We may send you appointment reminder cards.
- We may share your information with a pharmacist.
- We may fax your information to your insurance company.

Payment: Your PHI may be used as needed to obtain payment for your health care services. For example:

- Sharing information to determine eligibility of coverage and benefits.
- Obtaining approval for a hospital stay.
- Providing information for delinquent accounts.

Health Care Operations: We may use or disclose your PHI in order to operate our business. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing and fund rasing activities, such as newsletters about the practice.

In addition, we may use a sign-in sheet at the front desk. We may also call your name in the waiting room. We may use or disclose your PHI to contact you to remind you of any appointment.

We will share your PHI with third party "business associates" that perform various activities (e.g. billing, transcription) for the practice. Whenever an arrangement between our office and our associates involves disclosure of PHI we will have a written contract that contains terms that will protect the privacy of your PHI.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZARION, OR OPPORTUNITY TO OBJECT

The following categories describe scenarios in which we may use and disclose your PHI without your authorization. These situations include public health issues as required by law, communicable diseases, health oversight, abuse and neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, Workman's Compensation, and inmates.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

We may use and disclose your PHI only with your written authorization unless required by law. You may revoke this authorization at any time in writing, except to the extent that our physicians or the physicians' practice has taken action in reliance on the use or disclosure indications in the authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WITH AN OPPORTUNITY TO OBJECT

Subject to your objection, the practice may disclose your protected health information (PHI) in certain situations. If you are not present or able to agree or object to use or disclosure of your PHI, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed. The practice will inform you orally or in writing of such uses and disclosures, as well as provide you with an opportunity to object in advance. Your agreement or objection to the uses and disclosure can be oral or in writing. If you do not object to these disclosures, the practice is able to infer that you do not object.

Others involved in your care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or any other person responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your PHI 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 PHI in emergency treatment situations. Your physician shall try to obtain your consent as soon as is reasonably practical. If your physician is required by law to treat you and the physician has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your PHI.

Communication Barriers: We may use or disclose your PHI if your physician attempts to obtain consent from you, but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclose your PHI under the circumstances.

2. Your Rights

The follow is a statement of your rights in regard to your PHI.

You have the right to inspect and obtain a copy of your PHI: This includes your patient medical records and billing records, but not psychotherapy or other mental health records. Also not included is information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

To inspect and copy medical information, you must submit a request in writing to Privacy Officer, South Jersey Allergy and Asthma Associates. Our practice may change a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances. You may request to review our denial; another licensed health care professional chosen by us will conduct the review.

You have the right to request a restriction of your protected health information: This means that you may ask us not to use or disclose any part of your PHI for the purposes of TPO. You may also request that any part of your PHI 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 restrictions and to whom you want the restrictions to apply. Your physician is not required to agree with the restrictions you may request. If your physician believes it is in your best interest to permit use or disclosure of your PHI, your protected health information will not be restricted. You then have the right to use another health care professional. If your physician does agree to the request of restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by submitting a written request Attention to the Privacy Officer at South Jersey Allergy and Asthma Associates.

Confidential communications: You have the right to request our practice to communicate with you by an alternative means or at an alternative location. In order to request a type of confidential communication, submit a written request to Privacy Officer at South Jersey Allergy and Asthma Associates. Our practice will accommodate reasonable requests. You do not have to give a reason for your request.

Right to amend: You may request us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request in writing or it does not include a reason to support that request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the individual or entity that created the information is not available to amend that information. Also, information that is considered accurate and complete. Submit your request in writing to Privacy Officer, South Jersey Allergy and Asthma Associates.

Right to an accounting of disclosures: You have the right to request an "accounting of disclosures." This is a list of some of the disclosures we made of medical information about you that were not specifically authorized by you in advance. All requests for "accounting of disclosures" must state a time period which may not be longer than six years from the date of the disclosure and may not include dates before April 14, 2003. The first list you request within a twelve-month period is free of charge, but our practice may charge you for additional lists within the same twelve-month period. Our practice will notify you of the cost involved in any additional requests.

Right to a paper copy of this notice: You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing to Privacy Officer, South Jersey Allergy and Asthma Associates. You will not be penalized for filing a complaint.

We reserve the right to change the terms of this notice and will inform you by mail of any changes.
We will post a copy of the current notice in the office.

Privacy practices:

- Our office is equipped with a shredder to destroy patient's medical information.
  (i.e. duplicate test results, faxes received in error, and daily patient lists)
- The patients' charts are placed backwards in the bins outside the doors to keep names and test results from being seen by other patients.
- We provide music and a television in the waiting room to give patients more privacy.