
Dr. Michael D. Kohen, M.D.
Allergy



Dr. Vinicius Domingues, M.D.
Rheumatology

Dear New Patient,

Welcome to the Allergy, Asthma, & Arthritis Center. Attached is our New Patient Paperwork.

Please Complete the entire packet and bring it with you. -

(If you cannot print out and bring the paperwork with you, please *arrive 30 minutes prior to your appointment time* to complete the packet in our office.)

We are a Specialty Physician Office and your insurance company may require a pre-approval (Referral) for you to be seen. Referrals MUST be obtained from your Primary Care Physician and faxed to our office PRIOR to your appointment date.

Please allow 2 hours for your first appointment and we ask that you DO NOT wear any Colognes or Perfumes to the office since many of our patients have allergies.

Please bring the following items to you appointment:

1. Photo ID an Insurance Cards
2. New Patient Packet
3. List of Current Medications (including dose)
4. Lab Work & Imaging Reports Related to the reason for your visit.

New Allergy Patients:

1. DO NOT take any antihistamines or decongestants 5 days prior to your appointment to allow for allergy testing.
2. Bring any previous allergy testing results.

All New Patients:

Please arrive on time for your appointment. Tardiness, incomplete medical information or failure to provide a necessary referral will require your appointment to be rescheduled.

A minimum 24 hour notice is required if you are unable to make your appointment or need to reschedule. Monday appointments must be cancelled by 3:45pm on Friday.

A \$35.00 fee will be applied if a 24 hour notice is not given.

Thank you for your cooperation and we look forward to seeing you.

Patient Name: _____ D.O.B: _____ Today's Date: _____

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Patient Registration and Verification Form

PATIENT INFORMATION

First Name:		Last Name:		Date of Birth:
Mailing Address:				
City/ State/ Zip:				
Home Phone:		Cell Phone:		Preferred Contact Method: <input type="checkbox"/> Home <input type="checkbox"/> Cell
E-Mail Address:				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
Race: <input type="checkbox"/> American Indian or Alaska <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline				
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not hispanic or Latino <input type="checkbox"/> Decline				
Emergency Contact Name:		Emergency Contact Number:		Relationship to Patient:
Primary Care Provider:		Primary Care Providers Number:		

INSURANCE INFORMATION

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holders Name:	Policy Holders Name:
Policy Holders Date of Birth:	Policy Holders Date of Birth:
Member Number:	Member Number:
Patients Relationship to Policy Holder:	Patients Relationship to Policy Holder:

Patient Name: _____ D.O.B.: _____ Today's Date: _____

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Patient History

Briefly describe the reason for your office visit today and what you hope to accomplish:

Are you allergic to Latex? Yes No

Are you allergic to any Medications? Yes No (If YES, Please List ALL)

List of any surgeries you have EVER had and year performed:

Social History:

Marital Status: Single Married Divorced Widow(er)
Tobacco Use: Never Smoked Current(Occasional) Smoke Daily Quit (If yes when? _____)
Alchoho Use: Social Drinker Recovering Alcholoic Never Drink Alcohol

Family History:

Father:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Frequent Pneumonia
	<input type="checkbox"/> Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other Allergies	<input type="checkbox"/> Cancer (Type) _____
	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Deceased Age _____
Mother:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Frequent Pneumonia
	<input type="checkbox"/> Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other Allergies	<input type="checkbox"/> Cancer (Type) _____
	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Deceased Age _____

Adopted or No Family History Available:

Previous Allergy Evaluation and Therapy:

Have you ever been allergy skin tested? Yes or No
 If yes, date or year testing _____ Physician's Name: _____

Food Reactions: Have you ever had any symptoms (rash, hay fever, vomiting, age, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid?

Food	Symptoms	Can Food Be Eaten?	Date food was last eaten

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Patient History Cont.

Problems: Have you ever had the following conditions?					
		Age at Onset			Age at Onset
Yes No	Asthma		Yes No	Sudden Loss of Vision	
Yes No	Any Other Breathing Problems		Yes No	Dry Eyes	
Yes No	Sinus Problems		Yes No	Dry Mouth	
Yes No	Hay fever (runny, stuffy, itchy nose, sneezing)		Yes No	Mouth Ulcers	
Yes No	Hives or Swelling		Yes No	Sun Sensitivity	
Yes No	Eczema or Other Rashes		Yes No	Permanent Skin Color Change	
Yes No	Frequent Infection		Yes No	Psoriasis	
Yes No	Drug Reaction		Yes No	Bald Places on Scalp/Body	
Yes No	Insect Reaction		Yes No	Headaches	
Yes No	Food Reaction				

Symptoms: Have you ever had any of the following conditions?														
		How Many Days Last Month?	Circle the Months Most severe											
Yes No	Runny or Stuffy Nose		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Itchy Eyes		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Wheezing		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Coughing		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Wheezing or Coughing w/ Exercise		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Skin Problems		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Yes No	Sleeping Problems		Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.

Precipitating Factors/ Triggers: For each item below, check the appropriate answer.								
Made Worse	Made	No Change		Made Worse	Made	No Change		
			Cutting or playing in grass, raking leaves				Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc..	
			High winds, riding in a car					
			Other outdoor exposure					
			Mold/areas w/ mildew (attic, basement)				Trips away from home	
			Sweeping, dusting or vacuuming				Other strong odors (perfume etc..)	
			Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream toothpaste, etc..				<u>Medications:</u>	
							Antihistamines or cold preparations	
							Asthma medications	
			Cold or viruses				Nose drops or spray	
			Cold weather				Exposure to animals. Specify:	
			Smog, smoking, or smoke exposure					

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Medication & Pharmacy Information:

Please list all medication that you take, both prescription and non-prescription:

<u>Medication:</u>	<u>Dose:</u>	<u>How Often:</u>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

<u>Medication Allergies:</u>

<u>Preferred Local Pharmacy:</u>	<u>Phone Number:</u>

<u>Preferred Mail Order Pharmacy:</u>

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Allergy, Asthma & Arthritis Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care options (TPO). The Notice of Privacy Practices provided by Allergy, Asthma & Arthritis Center describes such uses and disclosures more completely. Note: This can be found on the last page of the new patient paperwork.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Allergy, Asthma & Arthritis Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Allergy, Asthma & Arthritis Center, 709 N Clyde Morris Blvd., Daytona Beach, Florida 32114.

With this consent, Allergy, Asthma & Arthritis Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Allergy, Asthma & Arthritis Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Allergy, Asthma & Arthritis Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Allergy, Asthma & Arthritis Center may decline to provide treatment to me.

With this consent, Allergy, Asthma & Arthritis Center may disclose protected health information (PHI) to the people who are listed below.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Signature of Patient

Today's Date

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**HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
PURSUANT TO 45 CFR 164.508**

TO:

Name of Healthcare Provider/ Physician/ Facility

Street Address

City, State and Zip Code

Phone/ Fax Numer

Re:

Patient Name

Date of Birth

SSN (Last 4):

I understand:

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508(c)(2)(I-iii)

- 1) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- 2) The information released in response to this authorization may be re-disclosed to other parties.
- 3) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient, or Legal Authorized Person

Relationship to Patient

Todays Date

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Financial Policy

Your health is first and foremost. Medical care will always be rendered on the basis of need, and no other factor will affect the quality of that care.

This is an agreement between Allergy, Asthma & Arthritis Center as creditor, and the patient/debtor named on this form. By executing this agreement, you are agreeing to pay for all services that are received. In the event that a patient does not meet their financial obligation, the patient will be discharged from the practice.

Payment Option If You Have No Insurance:

You may choose to pay by cash, check, or credit. You are required to pay on the day that treatment is rendered.

Payment Options If You Have Insurance:

You may choose to pay by cash, check, or credit. The patient /debtor will be responsible for any deductibles or out-of-pocket expenses after insurance has paid. Co-Payments are due at time of service.

Insurance:

We will bill your insurance company that you have provided us with. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of you eligibility. You agree to pay all of the charges not covered by insurance or all charged deemed your responsibility based on a managed care contract. Additionally, it is the patients responsibility to notify us of any insurance changes.

Monthly Statement:

If you have an outstanding balance on your account, we will send you a monthly statement by mail. It will show the current patient balance that is the patient/debtor's responsibility. All balances must be paid in full prior to your next visit. Balances over 60 days will be sent to collections.

Referrals:

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization will result in a rescheduled appointment. It is the patients responsibility to get all information to his/her primary care doctor for processing within 7 business days prior to your appointment date. If the correct time is not allowed the patient may need to reschedule. We may send a request for this information as a courtesy to the patient but this action is not required.

Cancellations & No Shows:

A 24- hour notice must be given to reschedule or cancel an appointment to avoid any additional charges. If proper notice is not given a charge of \$35 will be applied. Monday cancellations must be done by 3:45pm on Friday.

Effective Date:

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the

Patients Name: (Please Print)

Patient Signature:

Today's Date:

OUR NOTICE OF PRIVACY PRACTICES

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.

Our pledge regarding your health information:

We understand that medical information about you and your health is personal. We create a record of the care and services you receive from us. We need this record to provide you with quality care, obtain payment for the services we provide and to comply with legal requirements. This notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors or Practice staff. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this Notice of our legal duties and privacy practices; and (3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at our Practice sites will follow the terms of the Notice. Our Practice sites may share medical information with each other for treatment, payment or practice operations purposes described in this Notice.

How we may use and disclose medical information about you:

The following categories and examples describe the different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, the ways we are permitted to use and disclose information will fall within one of the categories.

Description and Examples:

We may share medical information about you with another physician, a hospital or other health care provider involved in your care. For example, a hospital may need to see a part of your medical record before you have surgery.

For Payment: We may share medical information with Medicare or other health plans to obtain payment for services provided to you, to verify insurance coverage or to obtain authorization for further treatment. For example, an insurance company may need to see a part of your medical record before they will pay for the services.

For Practice Operations: We may share medical information as necessary to manage the medical, legal and financial affairs of the Practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information to provide legal and financial services to the Practice. Any business associate with whom we share medical information will agree in writing to protect your privacy.

Appointment Reminders: We may disclose medical information to remind you of an appointment. We will disclose only the date, time and location of the appointment.

Family Members and Friends: We will share medical information with a friend or family member that is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.

Worker's Compensation: We may report a work-related injury to a worker's compensation carrier or to advise your employer about a work-related injury.

To Meet Legal Requirements and for Public Health Activities: We may disclose medical information to a government agency that oversees medical practice in the State such as the Florida Agency for Health Care Administration or the Board of Medicine. We are also required to report certain diseases and conditions to the local unit of the Department of Health for its public health activities.

Law Enforcement, Lawsuits, Disputes and Reports of Abuse or Neglect: We may disclose medical information to an attorney or law enforcement official to comply with a court order, subpoena, discovery request or other legal mandate. We may also disclose medical information to assist law enforcement with investigating a crime. For example, we are required to report wounds resulting from violence and incidents of abuse or neglect.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat.

For Special Government Functions: We may be required to disclose medical information to a government agency for

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For Special Government Functions: We may be required to disclose medical information to a government agency for national security purposes to a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran.

Organ and Tissue Donation: We may disclose medical information to an organization that handles organ, eye or tissue transplantation.

Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about individuals to funeral directors as necessary to carry out their duties.

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Medical Information:

You May Access Medical Information: To access your medical information, you must submit your request to us at our address listed below. If you request copies, we may charge a fee allowed by law. We may deny your request in certain very limited circumstances.

You May Amend and/or Correct Your Medical Information: You may ask us to amend or correct your medical information. Please make your request in writing and submit it to our office, address listed below. You must provide a reason that supports your request.

You May Request an "Accounting of Disclosures": You may request a list of the disclosures we made of medical information about you, other than for treatment, payment or Practice operations as described above, and without your written authorization.

You May Request Restriction on the Use or Disclosure of Your Medical Information: You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or Practice operation. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You May Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will try to accommodate all *reasonable* requests.

You have the right to a paper copy of this notice. You may ask us to give you a paper copy of this notice at any time.

Changes to this notice: We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in prominent locations at our Practice sites. The Notice will contain the effective date.

Exercise of Privacy Rights and Complaints: To exercise your privacy rights or to file a complaint, contact us at our address

Allergy, Asthma, Arthritis Center
Compliance Officer (Office Manager)
Michael D. Kohen, M.D., P.A.
709 N. Clyde Morris Blvd.
Daytona Beach, FL 32114

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Room 509 F, HHH Building
Washington, D.C. 20201