Allergy & Asthma Center
Anita N. Wasan, MD, FAAAAI, FACAAI
6824 Elm Street, Suite 120, McLean, VA 22101
Tel: 703-992-7065, www.novaallergy.com

Date of Visit:	
Patient Name:	DOB:
Address:	
Cell Phone Number:	
Insurance Name and ID:	
Subscriber Name + DOB:	

Preferred pharmacy name + **Address, City, State and Zipcode**:

Please list primary care provider and any specialist physicians you see, **including city, state and phone number**:

Any drug allergies? If yes, please list approximate age of reaction and symptoms, **Include Severity**: Very mild / Mild / Moderate / Severe

List all medications (prescription and over-the-counter) **Including Dosage**:

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Reason(s) for Visit:	
Are you able to be skin tested today? (You have not had any antihistamines for 3-5 days)	
Do you take beta blockers for heart palpitations / high blood pressure / anxiety?	

Please list any hospitalizations, surgeries, and medical conditions you have:

Please list any medical conditions that exist in your family:

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Type of Housing (i.e. single family home, townhome, condo, apt)	
When was the home built?	
Does your home have carpeting? Where and how old?	
Any pets? If yes, please list how many and what type?	
Do you smoke? Have you ever smoked? Are you exposed to smoke? Include e-cigarettes, marijuana, and hookah.	
How many alcoholic beverages do you drink per week, on average?	
Occupation	
Were you referred to by anyone today or google?	

Circle any symptoms that pertain to you:			
Headaches	Nasal congestion	Suicidal thoughts	Lymph node swelling
Vision loss / changes	Trouble falling asleep	Nerve pain / tingling	Breast lumps / masses
Hearing loss / changes	Trouble staying asleep	Arthritis / joint pain	Constipation
Sinus pressure	Snoring	Rash / eczema	Diarrhea
Post nasal drip / throat clearing	Mouth breathing	Hives	Bloating / gas
Cough	Heart palpitations	Difficulty in moving extremities	Abdominal pain
Chest pain	Depression	Swelling	Nausea / vomiting
Shortness of breath	Anxiety	Neck pain	Difficulty in urination
Menstrual irregularities	Hair loss	Cold / heat intolerance	Thyroid problems
Difficulty breathing with exercise / exertion	Frequent illnesses	Food allergies	Food sensitivities

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PRIVACY AND CONFIDENTIALITY RELEASE OF INFORMATION

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice describes your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in our electronic medical record system, Practice Fusion. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

1. I give permission for Dr. Anita Wasan or staff to discuss my treatment with my spouse/partner/family members about my presence in the office. Such discussion may include my diagnosis and treatment.

YES_____ **NO**_____

Names of person (s) I designate:

_____

2) I give permission for Dr. Anita Wasan or staff to discuss my appointments, my treatment, or test results I have had with the above person (s) I have designated when I may/may not be present.

YES_____ **NO**_____

3) I give permission for Dr. Anita Wasan or staff (and the Electronic Medical Record) to leave messages/emails/texts for me regarding appointments and/or test results. I give permission to leave voice mails on the answering machine/voice mail on the telephone number below which I designate.

YES_____ **NO**_____

Telephone number to leave a voice mail message is:

_____

I can revoke this authorization at any time in writing.

Patient Signature: _____

Date: _____

Assignment and Release

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I, the undersigned, have insurance coverage with _____ (name of insurance company) and assign benefits, if any, directly to the Allergy and Asthma Center, otherwise payable to the insured for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If any amount due remains unpaid after a bill is rendered, I agree to pay all costs of collection, including reasonable attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that secondary insurances will not be billed by the Allergy and Asthma Center.

_____ _____
Signature of Insured/Guardian Date

Release of Medical Records to our Practice from other Health Care Providers

I, undersigned, authorize the Allergy and Asthma Center, to obtain any medical records that may pertain to my medical care. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and thereby release the Allergy and Asthma Center, and staff, from all legal responsibility that may arise from the authorized.

_____ _____
Signature of Insured/Guardian Date

Notice of Privacy Practices

I have received and reviewed a copy of the Allergy and Asthma Center's Notice of Privacy Practice. My questions have been fully answered. If you would like a copy please request it at our front desk.

_____ _____
Signature of Insured/Guardian Date

Consent for Purposes of Treatment, Payment and Healthcare Operation (Reproduced from AMA/ACP model)

I consent to the use or disclosure of my protected health information by the Allergy and Asthma Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation of the Allergy and Asthma Center. I have the right to revoke this consent, in wiring, at any time, except to the extent that Anita N. Wasan, MD or the Allergy and Asthma Center taken action, relying on this consent. "Protected health information" is the health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information involves my past, present or future physical or mental health or condition and identifies me (or on a reasonable basis, identifies me).

_____ _____
Signature of Insured/Guardian Date

FINANCIAL POLICY

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This Practice has contracts with most commercial insurance companies. However, the Allergy and Asthma Center cannot guarantee payment by insurance companies for the visits and/or procedures done. Each patient's insurance plan is different and can involve copays, co-insurances and/or deductibles. If the patient's responsibility to be familiar with his/her plan prior to being seen and evaluated by our providers. Effective January 22, 2020, the practice also participates in Medicare. If you obtain medical services from the Allergy and Asthma Center, the patient (signing below) understands that the patient/ beneficiary or legal representative accepts **full responsibility** for payment of the physician charges/services furnished by the physician. It is the **patient's responsibility** to check their benefits with their insurance company. We do **not** submit any claims to secondary insurance companies.

It is the responsibility of the patient to make sure they have secured any referrals (for insurance purposes) that are required for their office visit; this referral will need to be provided at the time of the appointment. Patients/guardians are responsible for any outstanding balances that may arise out of not having the appropriate referral.

Our office checks patient's benefits to the best of our abilities prior to your appointment. If we determine that the patient has an individual deductible of $400 or more at the time of the visit, the following will be collected in advance of performing the procedures: $200 for any skin tests (CPT code 95004) of 25-40 pricks, $100 for 24 or fewer pricks, $300 for more than 40 pricks. $250 will be collected for any patch tests (CPT code 95044) if the individual deductible is $400 or more. All payments will be applied to your deductible amounts per our billing company. After submitting the claims to the insurance company, if there is a credit due, we will post the credit to your account.

The Allergy and Asthma Center outsources our billing to a third party called Medco Global Services, LLC at 443-283-8104. If you have any outstanding balances on your account, the practice reserves the right to collect the full amount before further services are rendered.

Telemedicine appointments are billed as office visits, and the necessary copay(s) will be collected prior to the appointment as well.

Any laboratory tests that are ordered are ordered through a third party commercial laboratory at the choice of the patient. It is the patient's responsibility to ensure that the laboratory is in network with his/her insurance company prior to getting the test done.

If you are part of an HMO or an insurance company that requires a referral to see a specialist, it is the patient's responsibility to obtain the necessary referral from the primary care physician **BEFORE** your visit. If a referral is not obtained at the time of your visit, you will be responsible for the entire amount of the visit at the time of service. If we have a contract with your plan, we will file a claim with your insurance company upon receipt of an updated insurance card. You are responsible for all charges that are not covered by your insurance company (i.e. deductibles, copays for a specialist visit, coinsurance). These amounts will be due within one month of your visit. A bill will be sent out to your home once we get the EOB (explanation of benefits) from your insurance company.

Your copay for a **specialist** office visit is **due at the time of your visit.** We accept cash, checks, Visa, and MasterCard. There is a $50.00 charge for returned checks. If you fail to pay your balance to Allergy and Asthma Center and it becomes necessary to take action to collect on your account, you agree to pay for all costs in the collection of your balance including any collection agency and attorney fees.

The Allergy and Asthma Center has a 24 hour cancellation policy. There is a $75.00 fee for missed new patient appointments and a $50.00 fee for missed follow up patient appointments and a $100.00 fee for any missed food, drug, or environmental challenge appointments.

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Forms: There is a $25 form fee for each patient at the time of the receipt of the forms by the provider. Please allow 48-72 hours (business days) for the forms to be completed by the provider. All form fees need to be collected prior to sending the forms to the appropriate location. We do not mail allergy serum vials. Any delivery of the vials is the responsibility of the patient and/or guardian.

ELECTRONIC MEDICAL RECORD SYSTEM

The Allergy and Asthma Center uses an electronic medical record system with a patient portal through HIPAA compliant Practice Fusion. By allowing the provider to see patient/guardian at the time of the visit, the patient/guardian consents to his/her chart being part of the Practice Fusion Electronic Medical Record System. Once making theappointment, the patient should receive an email with a portal link to create an account. The patient should also receive an appointment confirmation with a link to complete part of the patient intake forms. We do not accept forms via email or by cellular device. If you need to send us any forms or images, please create a portal account and send the appropriate forms or images via the secure portal. The portal allows the patient to communicate **non-urgent** messages to the provider and to also view lab results. Please allow at least 3 (three) business days for the provider to respond to your message via the portal. If you don't hear from the provider for three business days, please call the office. Appointments can be made through our website, www.novaallergy.com.

MEDICAL EMERGENCIES

In case of medical emergencies, please do **not** call us and leave a voicemail or message us through the portal. If the patient is having an emergency, please call 911 and go to your nearest emergency room or urgent care center. Please inform us if the patient did have a medical emergency so that we can do our best to arrange follow up care.

I have read and understand the above policies of the Allergy and Asthma Center and agree to comply with it.

Signature: _____ Printed Name: _____ Date:_____

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TELEMEDICINE PATIENT CONSENT FORM

Telemedicine, according to the Centers for Medicare & Medicaid Services, is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." There are multiple criteria (video face-to-face consultation, for example) for both patient and provider to fulfill in order for a consultation to be deemed an appropriate Telemedicine visit. We are requesting Allergy and Asthma Center patients acknowledge the following:

1. I understand that all federal and Virginia state laws protecting the privacy and confidentiality of medical information also apply to telemedicine.
2. Video conferencing with your provider will be through the HIPAA compliant telemedicine service provider DOXY.ME.
3. My healthcare provider has explained to me how the video conferencing technology will be used and that the visit may not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
5. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit and future telemedicine visits at any time. I understand that withdrawal of my telemedicine consent will not affect my future care nor treatment with this company.
6. I understand that certain procedures such as a complete physical exam, allergy testing, or pulmonary function testing cannot be performed via telemedicine.
7. I understand my health care provider may feel the telemedicine discussion may not be adequate and may request an actual visit to the office for more detailed consultation and examination. If that is so, I will only be charged for the in-office consultation.
8. I understand that my insurance may not pay for this telemedicine service, even if my provider feels this is a healthcare treatment option I need.

My Responsibilities:

1. I understand that I must be physically within the state of Virginia or District of Columbia (including offshore State waters) to be eligible for telemedicine and that my healthcare provider can send prescriptions for medications only to Virginia pharmacies or addresses. My provider will not be sending narcotic medications through a telemedicine-based consultation.
2. I will not record any telemedicine session without written consent from the Allergy and Asthma Center. My healthcare provider will not record any telemedicine session without my written consent
3. I will inform my healthcare provider as soon as my session begins if there are any other surrounding people that are listening or watching the session. If there are surrounding people that will stay for the session, I am giving my consent for them to listen in on my medical care.
4. I will notify my healthcare provider if there is any point in the consultation that my equipment fails and I am unable to have clear audio.

In signing my consent below, I certify:

• That I have read or had this form read and/or had this form explained to me • That I fully understand its contents including the risks and benefits of the procedure(s) • That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient/Guardian Signature: _____

Name of Patient: _____ DOB: _____

Today's Date: _____

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Release of Medical Information

_____
Patient Name DOB

_____
Address

_____
City, State, Zip

_____
Telephone Number (Mobile)

(OFFICE STAFF TO FILL OUT REQUEST)

I authorize the release of my medical records to:

_____

My medical records are to be released from:

_____

Date of treatment: _____ Send via: _____

Record Content:_____

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by myself at any time except to the extent that the action has been taken in reliance upon it. I acknowledge and hereby consent that the released information may contain HIV testing, HIV results, and/or AIDS information. The facility (Anita N. Wasan MD PLC) is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Date:_____ Relationship of Undersigned to patient:_____

Signature: _____