

**Asthma & Allergy Physicians of Rhode Island
Patient Information Sheet**

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work): _____ (Cell): _____

Date of Birth: _____ SS#: _____ Email Address: _____

Employed By: _____ Spouse, Parent, Guardian's Name: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____ Insurance Number: _____

Effective Date: _____

Insured's Name: _____ Date of Birth: _____ SS# _____

Secondary Insurance: _____ Insurance Number: _____

Effective Date: _____

Secondary Insured's Name: _____ Date of Birth: _____ SS# _____

Insured's Employer: (Primary) _____ (Secondary): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Would you be interested in Participating in a Research Study: Yes or No (Please circle your one)
(Answering yes does not commit you to any studies)

You may contact me if you feel I may be eligible to enroll as a study patient: _____

I would rather not be approached about any studies even if I were eligible: _____

CONSENT FOR HEALTHCARE OF MINORS

Because my son/daughter is a minor (less than eighteen years of age and primarily supported by parent or guardian), I understand and agree that he/she may be evaluated and/or treated by Asthma & Allergy Physicians of Rhode Island staff if I am not present to give consent. This may include but not necessarily be limited to physical exams, skin test, allergy injections and the prescription of medications in my absence. This agreement will be in effect until revoked by me in writing.

Signature of parent or guardian: _____ **Date:** _____

BILLING PROCEDURE

The office participates with most insurance carriers in the state as well as several carriers out of state. If you have health coverage with any of these carriers, we will automatically bill them for their contracted portion of your care. In most other situations we will provide you with a copy of our encounter form, which you may then submit to the carrier for reimbursement. This encounter form has the information required by most insurance companies. Your signature is required in all cases where we will be submitting on your behalf to the carrier.

Signature: _____ **Date:** _____

How did you hear of this office: (Please circle one or more)

Physician's name: _____ Friend or Yellow Pages

Allergy & Asthma Physicians of Rhode Island

ALLERGY

PLEASE REMEMBER!!!! Prior to the first visit please stop all allergy medications (antihistamines (not Singulair or Accolate) such as Allegra, Zyrtec, Claritin, Clarinex or over the counter allergy medications for 4 days prior to the first visit). This even includes **Tylenol PM** unless your symptoms are very severe (you cannot be tested if your are on antihistamines). Also stop asthma inhalers such as Albuterol Proventil, Ventolin, Maxair or Alupent 6 hours before the first visit (only if your asthma is stable and you are not wheezing). Do not take long acting bronchodilators such as Serevent, Foradil or Advair 12 hours prior to the visit, again only if your asthma is stable.

Allergy Questionnaire:

No Perfume or Cologne Please

Patient's name _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: (H) _____
(W or cell) _____

Date of Appointment: _____ Referring Physician or person or source _____

INSTRUCTIONS: Please answer the questions as they related to the patient being evaluated. A complete and accurate record helps us better understand your allergy problem. Please bring this sheet to your first appointment. Some of the questions may not be relevant to you. Please skip those areas on the form.

Briefly describe the reason for your allergy visit:

PROBLEMS: Have you ever had or been diagnosed with any of the following conditions?

Yes	No	(Check all items)	Age at Onset	Severity mild mod.	Comments Sev.
		Asthma			
		Any Breathing problems			
		Sinus Trouble			
		Hay Fever (runny nose, stuffy Itchy nose, itchy eyes or sneezing)			
		Hives or Swelling			
		Eczema or other rashes			
		Frequent Infections			
		Food Reactions			
		Insect Reactions			

Symptoms: Have you ever had any of the following? If not, leave blank.

How many days in last month	Circle months most severe
Runny or Stuffy nose	J F M A M J J A S O N D
Itchy Nose	J F M A M J J A S O N D
Sneezing	J F M A M J J A S O N D
Itchy Eyes	J F M A M J J A S O N D
Wheezing	J F M A M J J A S O N D
Coughing	J F M A M J J A S O N D
Wheezing or Coughing with exercise	J F M A M J J A S O N D
Skin Problems	J F M A M J J A S O N D

Precipitating Factors/ Known Triggers:

Please list any factors such as dust, animal exposure, change in environment or temperature, pollens, known to may you symptoms worse

Previous Allergy Evaluation and Therapy:

Have you ever had Allergy Skin test? YES _____ NO _____

If Yes, Date _____ Physician's Name _____

Results of these tests:

Allergen Immunotherapy (allergy shots)? YES _____ NO _____ Dates: _____

Benefit: YES _____ NO _____; Problems with allergy shots? YES _____ NO _____

Current Allergy Medications:

Previous Allergy Treatment:

Other Medications: (Currently taking – prescription and otc, include Herbal Meds).

Drug Allergies: (Please describe reactions):

Past Medical History:

(Please describe any medical problems for which you are currently under the care of Physicians)

Hypertension: YES _____ NO _____
Diabetes YES _____ NO _____
Recent Chest X-ray YES _____ NO _____

Recent sinus imaging: YES _____ NO _____
Heart Disease YES _____ NO _____
If Yes, what type? _____

Recent Hospitalizations: (Please describe and include dates):

Family History: Asthma YES ___ NO ___ Hay Fever YES ___ NO ___ Eczema YES ___ NO ___

Smoking History:

Have you ever smoked? YES ___ NO ___ If Yes, how many years? _____ If quit, when? _____

Do you presently smoke? YES ___ NO ___ If Yes, how much? _____

What is the average number of cigarettes per day at highest point? _____

Do other family members smoke? YES _____ NO _____, In house? YES ___ NO _____

Environmental Survey:

Where do you live? Rural _____ Suburban _____ City _____ Near the water _____

Describe any important factors about your home or work environment that you feel may be affecting your symptoms:

What type of work do you do? And how may this affect your symptoms?

Are any of the rooms in the house damp or musty?

Any areas at work damp or musty?

Age of house _____ Type of heating system(FHA,baseboard/FHW,Radiator,Gas stove) _____ Wood stove _____

Are condition: Central, window, and etc. _____ Bedroom?

Pets? _____ Type _____ Any pets at school or in work environment? _____

Do pets spend time indoors? _____ (Please note if they spend time in the bedroom)

Carpeting? Bedroom _____ Living room _____ Den _____ Dining room _____

Type of pillow and blankets? (feather or down, Dacron, other) _____

Are mattress or pillow encased in allergy-proof covers? Mattress: YES _____ NO _____ Pillow: YES _____ NO _____

Are you exposed to anything at work that might aggravate your condition? YES _____ NO _____

If Yes, Please explain?

Have you missed time from work or school because of your allergies or asthma? How much time?

Do you have other exposures or recreational hobbies that might aggravate your allergies or asthma?

Thank you for taking the time to complete this form. The staff looks forward to meeting you.
PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT.

ACKNOWLEDGEMENT OF RECEIPT OF
OUR NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been either provided with a copy or have read the Asthma & Allergy Physician notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by (Asthma and Allergy Physicians of Rhode Island) and how I may obtain access to and control this information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

(This section will be completed if the written acknowledgement not obtained)

- We have made a good faith effort to obtain an individual's Acknowledgement, but the acknowledgement was not obtained for the following reason(s):
- The individual refuses to sign or otherwise fails to provide an acknowledgement
- The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement
- Other:

Completed by: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: 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.

We are required by law to protect the privacy of your health information and to provide you with a copy of this notice, which describes the health information privacy practices of our medical practice. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copies by calling our office at 401-951-1235 or asking for one at the time of your next visit.

If you have any questions about this notice or if you would like further information, please contact Lisa Berndt, Manager at 401-751-1235.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of your health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health and related health care services. Some examples of protected health information include:

- that you are a patient of the medical practice or receiving treatment or other health-related services from our medical practice;
- your health condition (such as a disease you may have);
- health care products or services you have received or may receive in the future (such as an operation); and/or,
- your health care benefits under an insurance plan (such as whether a prescription is covered).

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We will obtain your written authorization before using your health information or sharing it with others outside the practice. You may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Lisa Berndt, Manager. However, most of our uses and disclosures of your protected health information are for the purposes of carrying out treatment, payment or health care operations or for other purposes that are permitted or required by law, and therefore, don't need your written authorization.

1. Treatment, payment, and health care operations: Your health information may be used and disclosed by your provider, 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 our medical practice. Below are examples of how your information may be used and disclosed for these treatment, payment, and normal business operations without your written authorization.

- **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, such as a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you such as 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.
- **Payment:** We may use your health information or share it with others so that we obtain payment for your health care services. This may include certain activities that your 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.

- **Health care operations:** We may use your health information or share it with others to conduct our business operations. These activities include, but are not limited to: assessing quality, evaluating employees performance, training medical students, licensing marketing and fundraising activities, and conducting or arranging other business activities. For example, we may use your health information to evaluate the performance of our staff in caring for you or to educate our staff on how to improve the care they provide for you. We may also disclose your protected health information to medical students whom see patients at our office. We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may call you by name in the waiting room when your physician is ready to see you.
 - **Appointment reminders, treatment, alternatives, benefits, and services:** In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services. We may also use your health information to provide you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.
 - **Business associates:** We may disclose or share your protected health information with third party “business associates” that perform various activities for our practice. For example, we may share your health information with a billing company that helps obtain payment from your insurance company. Other examples include sharing your health information with a transcription service that transcribes the physicians dictated progress notes or an accounting law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.
2. **Friends and family involved in your care:** If you do not object, we may share your health information with a family member, relative or close personal friend who is involved in your care or payment for that care.
3. **Emergencies or public need:**
- **Emergencies:** We may use or disclose your health information if you need emergency treatment or if we are required to by law to treat you but are unable to obtain your written authorization. If this happens we will try to obtain your written authorization as soon as we reasonably can after we treat you.
 - **As required by law:** We may use or disclose your health information if we are required by law to do so. We will notify you of these uses or disclosures if law requires notice.
 - **Public health activities:** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling who disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable or be at risk for contracting or spreading the disease if a law permits us to do so. We may also release your health information to the state's central cancer registry. Finally we may release some health information to about you to your employer if your employer hires us to provide you with a physical exam, and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.
 - **Victims of abuse, neglect or domestic violence:** We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.
 - **Health oversight activities:** We may release your health information to government agencies authorized to conduct audits, investigations and inspections of our office. These government agencies monitor the operation of health care systems, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil right laws.
 - **Product monitoring, repair, and recall:** We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems;

(2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

- **Lawsuits and disputes:** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain by a court order protecting the information from further disclosure and only with a written certification by the party issuing the subpoena in accordance with law.
 - **Law enforcement:** We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives, locating missing persons, or, if necessary, reporting a crime that occurred on our property.
 - **To avert a serious and imminent threat to health or safety:** We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).
 - **National security and intelligence activities or protective services:** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.
 - **Military and veterans:** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.
 - **Inmates and correctional institutions:** If you are an inmate or you are detained by a law enforcement officer, we may disclose with your health care information to the prison officers or law enforcement officers if necessary to provide you with health care or to maintain safety, security, and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.
 - **Workers' Compensation:** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.
 - **Coroners, medical examiners, and funeral directors:** In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties consistent with applicable law.
 - **Organ and tissue donation:** In the unfortunate event of your death, we may disclose your health information to the medical examiner for his other records.
 - **Other uses and disclosures:** While federal law allows providers to use and disclose patients' information for certain purposes to benefit the public (e.g., for scientific research, fundraising or marketing) without authorization, we do not currently use or disclose your information in these ways. We promise not to use or disclose your information for such purposes in the future without your authorization. Federal law prohibits us from breaking this promise to you.
- 4. Completely de-identified or partially de-identified information:** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

5. Incidental disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. Right to inspect and copy records: You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to [insert name of responsible person]. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

2. Right to amend records: If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records. To request an amendment, please write to [insert name of responsible person]. Your request should include the reasons you think we should make the amendment. If we deny part of or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.