ASTHMA & ALLERGY CARE, PC

SUNITA KANUMURY, M.D., F.A.C.A.A.I.
Diplomat of the American Board of Allergy and Immunology

NEW PATIENT INFORMATION

TODAY'S DATE: _____

NAME: _____DOB:_____

IF PATIENT IS A MINOR:

MOTHER'S NAME:_____

PHONE #:_____

FATHER'S NAME:_____

PHONE #:_____

PARENT TO BE CALLED REGARDING HEALTH CONCERNS: _____

PARENT TO BE CALLED WITH PAYMENT CONCERNS: _____

PRIMARY DOCTOR:_____

PHARMACY: _____

Patient Insurance Questionnaire

Patient's Name: _____ Date of Birth:_____Age: _____
Street Address: _____ Telephone (Home): _____
City: _____ Telephone: (Work): _____
State: _____ Zip: _____ Cell Phone/Pager: _____
Social Security Number: _____ Email Address: _____
Occupation: _____
Patient's Employer/Address: _____
Referring Physician/Address: _____
Additional Physician Reports to: _____
Sex: [ ]Male [ ]Female Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widow
Chief complaint: _____
Other Referral Sources: _____ Pharmacy:_____
Emergency Contact:_____ _____

Race:_____ Ethnicity:_____ Language:_____

PRIMARY INSURANCE (copy of insurance card is required)	**SECONDARY INSURANCE (copy of insurance card is required)**
Name of insurance company: _____	Name of insurance company: _____
Address: _____	Address: _____
ID or Policy #: _____	ID or Policy #: _____ __
Group #: _____	Group #: _____
Address: _____	Address: _____
Date of birth: _____	Date of birth: _____
Social security number: _____	Social security number: _____
Sex: [ ]Male [ ]Female	Sex: [ ]Male [ ]Female
Effective date of insurance: _____	Effective date of insurance: _____
Who is Subscriber: (check one) [ ]Self [ ]Spouse [ ]Parent [ ]Other: _____	Who is Subscriber: (check one) [ ]Self [ ]Spouse [ ]Parent [ ]Other: _____
If Subscriber is other than Self, complete following: Subscriber's name: _____	If Subscriber is other than Self, complete following: Subscriber's name: _____

FOR RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I accept responsibility and guarantee payment for all services rendered to me and my family. If my address, phone number or insurance information changes, I will notify the office immediately; otherwise, I will be personally liable for the full amount of the visit. Upon default on any payment due ASTHMA & ALLERGY CARE, I agree to pay all cost of collections including collection agency fees. I understand there is a $10.00 returned check fee should a check be returned for any reason.

I authorize the release of any medical information or other information as is necessary to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Asthma & Allergy Care, Dr. _____to apply for benefits on my behalf for covered services rendered by his/her, or by his/her order. I understand it is my responsibility to understand the provisions of my policy and to obtain necessary referrals, and authorizations from my PCP. I request that payment from my insurance carrier be made directly to Asthma and Allergy Care, PC. I understand that I am responsible to pay all charges not covered by my insurance company, and if payment from insurance is not received within 120 days that I will be responsible for the amount due. Any remaining balance on the account after the insurance pays will be due upon receipt of my statement or upon receipt of my explanation of benefits. Charges not payable by my insurance carrier are due immediately. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

Patient Health Questionnaire

Patient Name:_____Age:_____ Date:_____
Male:___Female:___ Referring Physician Address/Phone:_____
_____
Why are you seeing us? (Please describe.):_____
_____
_____

1. DO YOU HAVE ANY OF THESE?	**YES**	**NO**
Nasal congestion and/or runny nose	___	___
Itchy or watery eyes	___	___
Frequent sneezing	___	___
Snoring	___	___
Drainage down back of throat	___	___
Frequent yellow or green nasal drainage	___	___
Frequent headache	___	___
Coughing	___	___
Wheezing or shortness of breath	___	___
Diagnosis of asthma	___	___
Past hospitalization for asthma	___	___
Possible reaction to food or drug	___	___
Bee sting reactions	___	___
Rashes or eczema	___	___
Frequent sinus infections/bronchitis	___	___

2. SYMPTOMS OCCUR MOST OFTEN:
Spring___ Summer___ Fall___ Winter___ Year round___

3. SYMPTOMS WORSEN/CHANGE WITH:

___Cold air	___Plants (poison ivy)	___Raking leaves
___Cigarette smoke	___Dusting or cleaning	___Weather change
___Chemicals	___Colds/flu	___Exercise
___Aerosols sprays	___Pets (cat, dog, bird, other)	___Sunscreens
___Cosmetics	___Fresh cut grass	

4. LIST YOUR CURRENT MEDICATIONS # or mg tabs, caps or inhaler puffs Times per day

_____ _____
_____ _____
_____ _____
_____ _____

Previous pets:_____Mice/roaches: ___Yes

7. HOSPITAL VISITS/SURGERIES: _____
_____

8. IMMUNIZATION STATUS: Are your vaccines up-to-date? ___Yes ___No
Describe:_____

9. PAST ALLERGY CARE: _____
10. DO YOU HAVE ALLERGIC REACTIONS TO:

Aspirin: _____	Plants: _____
Sulfites: _____	Soaps/fabric softeners/cosmetics: _____
Medications: _____	Latex rubber: _____
Foods & additives: _____	Vaccines: _____
Insect stings: _____	Other: _____

11. FAMILY HISTORY: Parents:_____
Siblings:_____ Other: _____

12. SOCIAL & WORK HISTORY: Occupation:_____
Work exposure: _____
Skin sensitivities: _____
Sensitivity to chemicals/smells/newspapers: _____
Alcohol usage: _____
Drug usage: _____
Tobacco history: ___Yes ___No Please describe: _____
Secondary tobacco exposure: _____

Asthma & Allergy Care, PC
Sunita Kanumury, M.D.
ADULT AND PEDIATRIC ASTHMA, ALLERGY, AND SINUSITIS

GENERAL CONSENT
PATIENT/ GUARANTOR AGREEMENT

I,_____, give my consent to SUNITA KANUMURY, M.D.

to examine, prescribe, perform all necessary tests and provide treatment.

Understanding this, I hereby authorize the above named doctor or whomever she may designate to administer such treatment.

I understand that my insurance policy is a contract between me and my Insurance Company and I am responsible for any charges not covered by insurance. Any balance on the account after insurance pays will be due payable by me.

I herby authorize the release of any and all medical and /or charge information as is necessary for third-party reimbursement from Medicare, any private Insurance and/or any agency involved in the payment of my treatment.

During the course of treatment, if any healthcare workers in the practice become directly exposed to blood or body fluids, as per State Law I would consent for a sample of my blood tested for the presence of infectious diseases. The results will be released to me and to the healthcare workers who suffered exposure.

The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by this practice.

I, _____, ( ) acknowledge receipt this day from ASTHMA & ALLERGY CARE, P.C. of a copy of the NOTICE OF PRIVACY PRACTICES of ASTHMA & ALLERGY, P.C.

I understand it is the policy of ASTHMA & ALLERGY CARE to telephone me with results of blood tests, studies, etc. If not available, I expect and accept that a message may be left with those answering or as a voice message to call the office.

I give permission for my personal health information to be disclosed to the following people

only: _____

I wish to be contacted in the following manner (check all that apply):
____Home Telephone, ____Leave message with detailed information, ____Leave message with call back number only
____Work Telephone, ____Leave message with detailed information, ____Leave message with call back number only
____Written Communications, ____Mail to my home Address, ____Mail to my work/office address,
Fax written communications to this number ( )_____.

I understand that I may revoke or restrict these permitted disclosures, in writing, at any time.

SIGNED_____ WITNESS_____

DATE_____

***ACKNOWLEDGEMENT OF RECEIPT**
OF NOTICE OF PRIVACY PRACTICES*

I, _____, (insert patient's name) acknowledge receipt this day from ASTHMA & ALLERGY CARE, P.C. of a copy of the NOTICE OF PIVACY PRACTICES of ASTHMA & ALLERGY, P.C.

I understand it is the policy of ASTHMA & ALLERGY CARE to telephone me with results of blood tests, studies, etc. If not available, I expect and accept that a message may be left with those answering or as a voice message.

I give permission for my personal health information to be disclosed to the following people only:_____

Date_____ _____
(patient's signature)

Received By:

_____
(Print Name of Staff Member)

_____
(Signature of Staff Member)

Asthma & Allergy Care, PC
Sunita Kanumury, M.D

SIGNATURE ON FILE

____ I authorize use of this form on all my insurance submissions.

____ I authorize release of information to all my insurance carriers.

____ I understand that I am responsible for my bill.

____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

____ I authorize payment directly to my doctor.

____ I permit a copy of this authorization to be used in place of the original.

NAME_____ **MEDICARE#**_____
PLEASE PRINT **IF APPLICABLE**

SIGNATURE:_____ **DATE:**_____

Asthma & Allergy Care
Sunita Kanumury, M.D.
496 E. Main Street
Denville, NJ 07843
Tel : 973-627-1000 Fax : 973-627-0443

Regarding E-Mail Correspondence

We would be sending our correspondence via E-mail only.
Please provide us with your E-mail that you check most often and your cell phone.

Name: _____

E-Mail:_____

Telephone#:_____

How would you like to be contacted by?
E-Mail or Text

Tell us how did you hear about us?

__Internet, Website:_____

__Yellow Pages

__Primary Care Physician

__Current Patient

__Other_____

Like us on Facebook
https://facebook.com/asthmaandallergycarepc

Asthma & Allergy Care
Sunita Kanumury, MD
496E. Main Street
Denville, NJ 07843
Ph: 973-627-1000 Fax: 973-627-0443

Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information sheets before seeing the doctor.

NOTE: WE WILL SEND VIA EMAIL ONLY ANY BALANCES YOU MAY INCUR.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payments may be made by cash, check, Visa or MasterCard. We will only bill insurance carriers with whom we participate (have signed an agreement with).

Regarding Managed Care Insurance with which we participate: You are responsible to supply our staff with your primary and secondary insurance identification card(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. **If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full**. If your insurance requires a copay, it must be paid at the time of appointment.

At times your insurance carrier will deny payment for authorized services, if so you may be asked to help resolve these issues with your carrier.

Regarding Non-Participating Insurance(s): If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. We accept cash, check, Visa or MasterCard. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Our bank charges us a fee for any check that is returned for "insufficient funds". If this occurs the fee will be added to the patient's bill.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. Accounts that are referred to an outside agency or attorney for collection will be subject to a fee of $50.00 or 20% of the balance owed which ever amount is greater.

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns please feel free to ask. If you cannot pay in full at the time of service, please let us know that you would like to discuss a payment plan before you see the doctor.

Our practice is committed to providing the highest quality of treatment to our patients. If you have any question, feel free to ask us.

I have read the above Financial Policy of Dr. Sunita Kanumury, M.D. I understand and agree to abide by its terms.

_____ _____

Signature of Patient/Parent/Guardian Date