Allergy & Asthma Inc.

Hidayat A. Khan, M.D.
10794 Hickory Ridge RD
Columbia, MD 21044
Phone: (410) 964-3888 Fax: (410) 964-4405

We would like to take this opportunity to welcome you to our practice!

Below are several policies and procedures of our office. We hope that the information will be helpful to you as we are committed to providing you with the best quality of care possible.

CO-PAYS:
Our office participates with most insurance companies. You will be asked upon check-in to pay your co-pay. We have a contractual obligation with your insurance company to collect this co-pay.

REFERRALS:
Due to the many and constant changes that have occurred in the medical field in the past few years, it is now nearly impossible for our staff to maintain up-to-date referral schedules for our patients. Insurance companies are constantly changing their requirements throughout the year. Please contact your insurance company with all inquiries about referrals. You may also want to keep your own copies/records of your referrals so you can ensure you have one on file with us prior to your appointment.

As a reminder, it is YOUR responsibility as the patient to provide our office with a referral at the time of service; please contact your Primary Care Physician to get a referral. If you fail to provide us with a referral, you will be asked to reschedule your appointment or pay in full for the services at the time of your appointment. We are sorry for any inconvenience this may cause you.

SELF PAY PATIENTS:
Patients without insurance will be expected to pay for services rendered at the time of service. We accept cash, check and all major credit cards.

_____ _____

Patient/Parent/Guardian Signature Date

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*****New Payment Policy Effective January 1, 2015*****

Thank you for choosing us for your healthcare needs! Thank you for understanding and accepting these policies.

*Please inform the front desk of any changes in your address, phone number, insurance and email upon check-in.

*If your insurance plan requires you to pay a deductible, co-insurance you will receive a statement from our office and you are expected to pay this amount within a timely manner. Please talk to us if you are having trouble paying your bill, we will do our best to work out a payment plan with you.

*If you have a balance due on your account, you will be notified upon check-in of the balance and you will be expected to pay that amount at check-in.

*The no-show fee is $40.00, if there is no record of you calling to cancel your appointment within 24hrs of your scheduled time, this policy will be enforced and your account will be charged a no-show fee. Please note, insurance companies do not cover the cost of a no-show fee. If your child is a minor and you do not call to cancel his/her appointment, their account will be charged a no-show fee.

Name:_____

Signature:_____

Date:_____

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Formedic

NAME | MARITAL STATUS S M W D SEP | DATE OF BIRTH | DATE

STREET ADDRESS | CITY STATE, ZIP

PHONE # - HOME ( ) | WORK # ( ) | OCCUPATION/ EMPLOYER

SPOUSE'S NAME | DATE OF BIRTH | OCCUPATION/ EMPLOYER | PHONE # ( )

IF UNDER 18 **PARENT / GUARDIAN**

EMERGENCY CONTACT (OTHER THAN SPOUSE) | PHONE # ( ) | ADDRESS | RELATION

S.S. # | DRIVER'S LICENSE # | REFERRED BY

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT) | RELATIONSHIP

BILLING ADDRESS | PHONE # ( )

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY | ADDRESS | EFFECTIVE DATE

NAME OF INSURED | RELATION TO PATIENT | GROUP# | BENEFIT CODE

I.D.#

2) INSURANCE COMPANY | ADDRESS | EFFECTIVE DATE

NAME OF INSURED | RELATION TO PATIENT | GROUP# | BENEFIT CODE

I.D.#

MEDICARE I.D.# | MEDICAID I.D.#

OTHER COVERAGE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* | DATE

PARENT / GUARDIAN *(please print)* | SIGNATURE

HIPAA COMPLIANT

Allergy & Asthma, Inc.

Dr. Hidayat Khan, M.D.
Frederick: (301) 694-4935
Columbia: (410) 964-3888
Dundalk: (410) 282-2903

Patient's Name: _____ Date _____

Are you here for: ☐ Allergies ☐ Asthma ☐ Sinusitis ☐ Eczema ☐ Hives ☐ Other

☐ Yes ☐ No Have you had a diagnostic evaluation for allergies prior to this visit?
☐ Yes ☐ No Have you had any previous skin testing?
☐ Yes ☐ No Do you have records?
☐ Yes ☐ No Have you ever or are you now on "allergy shots"?
☐ Yes ☐ No If "Yes", did they or are they working?
☐ Yes ☐ No Have you ever been diagnosed or treated for eczema?

I. Nasal Symptoms ☐ Severe ☐ Moderate ☐ Mild

A. Symptoms

☐ Yes ☐ No Congested/stuffy/runs constantly/sniffles
☐ Yes ☐ No Sneezing/itching/rubbing
☐ Yes ☐ No Sinus trouble (headache, pressure, infections)
☐ Yes ☐ No Discharge is clear/watery/thick/colored
☐ Yes ☐ No Mouth breathing/snoring
☐ Yes ☐ No Post nasal drainage
☐ Yes ☐ No Bad breath
☐ Yes ☐ No Problem with taste
☐ Yes ☐ No Problem with smell
☐ Yes ☐ No Teeth pain
☐ Yes ☐ No Eye symptoms (itching, tearing, redness; light hurts)
☐ Yes ☐ No Recent cold - approximate date:
☐ Yes ☐ No Headaches oc daily weekly monthly
☐ Yes ☐ No If "Yes", details _____

B. Sleeping

☐ Yes ☐ No Normal
☐ Yes ☐ No I wake during the night because of:
Congestion/runny nose/cough/ short of breath/ chest tightness
☐ Yes ☐ No In the morning I have:
Congestion/runny nose/cough/ short of breath/ chest tightness

C. Time Frame/Seasonality

1) Nasal symptoms are present:

☐ Yes ☐ No Year round without any seasonal change
☐ Yes ☐ No (a) Year round, but gets worse at certain times
☐ Yes ☐ No (b) Only at certain times of the year

2) If the answer to (a) or (b) was "Yes", which months are symptoms either present or appreciably worse?

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

3) Nasal Symptoms have been present:

☐ Yes ☐ No More than 10 years
☐ Yes ☐ No 3-10 years
☐ Yes ☐ No Less than 3 years
☐ Yes ☐ No Recent X-ray/CT scan of Sinuses

4) Are you having:

☐ Yes ☐ No Recurrent sinus infection?

If "Yes"

Last Infection _____

☐ Yes ☐ No Antibiotics used _____

☐ Yes ☐ No Have you had sinus surgery?

If "Yes"

Date _____

5) Symptoms over the years are:

☐ Yes ☐ No Generally better than 6 years ago

☐ Yes ☐ No Generally getting worse each year

☐ Yes ☐ No About the same

6) Do you have:

☐ Yes ☐ No Recurrent upper respiratory infection?

☐ Yes ☐ No Recurrent ear infections?

D. Nasal Symptoms seem to be brought on or worsened by:

☐ Yes ☐ No Pollens

☐ Yes ☐ No Pet exposure

If "Yes", which: _____

☐ Yes ☐ No Dust

☐ Yes ☐ No Mowing grass/gardening/weeds

☐ Yes ☐ No Raking leaves/compost

☐ Yes ☐ No Damp basements

☐ Yes ☐ No Cigarette smoke

☐ Yes ☐ No Fumes (chemical, smog, auto exhaust)

☐ Yes ☐ No Weather changes (temperature, barometric pressure)

E. Recent medication you are using:

☐ Yes ☐ No Antihistamines

☐ Yes ☐ No Do they work?

☐ Yes ☐ No Nasal steroids

☐ Yes ☐ No Do they work?

II. Chest Symptoms

☐ Severe ☐ Moderate ☐ Mild

☐ Yes ☐ No Have you ever "wheezed", had asthma or asthmatic bronchitis?

If "Yes", indicate when:

☐ Yes ☐ No Only prior to age 12

☐ Yes ☐ No In childhood and more recently

☐ Yes ☐ No More recently

☐ Yes ☐ No Do you sometimes get a sensation of chest tightness, shortness of breath, spasmodic "tight coughing, and or wheezing?

☐ Yes ☐ No Chronic/ongoing

☐ Yes ☐ No Intermittent/infrequent

☐ Yes ☐ No Chest symptoms will be brought on by:

☐ Yes ☐ No Head colds/URI's/Viral infections

☐ Yes ☐ No Dust exposure

☐ Yes ☐ No Animal exposures

☐ Yes ☐ No Pollen exposures

☐ Yes ☐ No Exercise

☐ Yes ☐ No Cold air exposures

☐ Yes ☐ No Cigarette smoke exposures

☐ Yes ☐ No Exposure to odors (perfumes, gasoline, etc.)

☐ Yes ☐ No Weather changes (temperature, barometric pressure)

Because of chest symptoms THIS YEAR, did you: LAST YEAR

☐ Yes ☐ No Need to go to the Emergency Room
☐ Yes ☐ No Need hospitalization
☐ Yes ☐ No Use inhalers
☐ Yes ☐ No Use steroids
☐ Yes ☐ No Need chest X-ray
☐ Yes ☐ No Get pneumonia
☐ Yes ☐ No Get bronchitis

☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

When present, chest symptoms occur in:
☐ Morning ☐ Evening ☐ Night ☐ Variable

When present, chest symptoms occur:
☐ Seldom ☐ Occasionally ☐ Always

☐ Yes ☐ No Do (or have) you smoke(d)?
If "Yes", indicate when you started/stopped:

☐ Yes ☐ No Do you produce mucus/phlegm with coughing?
☐ Yes ☐ No Do you have chest discomfort or heartburn with meals or position changes (sitting or lying down)?

☐ Yes ☐ No Do you have chest pain or heartburn associated with shortness of breath, cough or chest tightness?

☐ Yes ☐ No Do you have: Reflux Disease/Peptic Ulcer Disease/Hiatal Hernia
If "Yes", list current medications _____

☐ Yes ☐ No Do the current medications work?

A. Cardiac Symptoms

Have you ever been diagnosed as having/had:
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Strok Heart Attack
☐ Yes ☐ No Swollen Ankles
☐ Yes ☐ No Leg Pain (Walking)
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Foot Pain (cold/numb)
☐ Yes ☐ No Dizziness/Fainting
☐ Yes ☐ No Arm/Leg Weakness
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Poor Circulation
☐ Yes ☐ No Irregular Heart Beat

Please Describe: _____

Treatment: _____

III. Skin Symptoms

☐ Yes ☐ No Do you have any contact allergy (e.g. latex, metal, cosmetic, soap, lotion)
☐ Yes ☐ No Have you ever had eczema or allergic skin problems?
Explain _____
☐ Yes ☐ No Have you been using skin creams? If Yes, please describe _____
☐ Yes ☐ No Are you taking antihistamines for this problem? If yes, please describe _____
☐ Yes ☐ No Is the eczema getting better or worsening?
Describe _____
☐ Yes ☐ No Have you seen a doctor about this problem,?
Describe _____

IV. Miscellaneous Symptoms

☐ Yes ☐ No Do you have any known drug allergy? Describe: _____
☐ Yes ☐ No Do you have any known food allergy? Describe: _____

☐ Yes ☐ No Do you have any stinging insect allergy? Describe: _____

☐ Yes ☐ No Have you ever had hives?

☐ Yes ☐ No Are there any family members with: allergies / asthma / sinusitis? (circle)

☐ Yes ☐ No Does your occupation involve exposure to fumes, dusts, or chemicals?

☐ Yes ☐ No Are your symptoms better or worse at work (than at home)? If yes, which?

_____

V. Environment

Occupation: _____

Living quarters is a: ☐ House ☐ Apartment ☐ Dorms ☐ Other

Heating system has:

☐ Forced air heat ☐ Hot water heat ☐ Other

Cooling system has:

☐ Window a/c's ☐ Central a/c's ☐ Evaporative cooler

☐ Yes ☐ No Are there pets at home?

If "Yes", what kind? _____

☐ Yes ☐ No Are there smokers at home?

If "Yes", who? _____

☐ Yes ☐ No Is there a basement in the home?

If "Yes", is it:

☐ Finished ☐ Dry

☐ Unfinished ☐ Damp/musty

In the bedroom, are there:

☐ Yes ☐ No Wall-to-wall carpet

☐ Yes ☐ No Feather or down pillows

☐ Yes ☐ No Regular (cotton) mattress/box spring sets

☐ Yes ☐ No Venetain blinds or lined drapes on windows

☐ Yes ☐ No Wool blankets or down comforters on the bed

☐ Yes ☐ No Humidifiers

PROVIDER 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.

Protected Health Information (PHI):

Each time you visit our office a record is made. Your symptoms, examination and test results, diagnoses, treatment and a plan form future care are recorded. This information is most often considered as PHI along with other information including but not limited to health insurance information, prescription history, your address, etc. We use PHI as a means of communication with other providers who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed to access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your PHI to others.

Understanding your health information rights:

Your health record is the physical property of our office but the content is about you, and therefore, belongs to you. You have the rights to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file.

Other than reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

Your health information will be used for treatment, payment, and health care operations:

Treatment – Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. We will share information with others involved in your care, such as specialists and lab technicians.

Payment – Your health information (PHI) will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – We will use or disclose your PHI to assess the care you received, and compare the outcome of your case to others like it. Your information may be reviewed for risk management or quality improvement purposes in our effort to continually improve the quality and effectiveness of the care and services we provide.

Understanding our office policy for specific disclosures:

- Business Associates – some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held be this office through terms detailed in a written agreement.

- Notification – Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or our whereabouts.

- Communications – Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care and/or recovery. We may contact you by telephone or mail to provide information on treatment, services, or products related to you care. Unless a written objection is on file, we may disclose to third parties who answer your phone limited health information regarding up-coming appointments or billing information, and we may leave messages on your voice mail system or answering machine with limited health information.

- Marketing - We may use or disclose certain health information in the course of providing you with information about treatment alternatives or health-related services. You may contact us to request that these materials not be sent to you.

- The following circumstances may lead us to use or disclose your health information without your authorization:
    - When law requires it
    - When it is necessary for public health activities.
    - When it is for health oversight activities.
    - When it is for judicial and administrative proceedings.
    - When it is for law enforcement purposes.
    - When it is to avert a serious threat to health or safety.
    - When it relates to specialized government functions.
    - When it relates to victims of abuse, neglect or domestic violence.
- You have the right to a copy of this Notice by contacting us in writing no later than the date you first receive service from us.

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services with no fear of retaliation by this office.

For further additional information or report a problem, you may contact:

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10794 Hickory Ridge Rd.
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Acknowledgement of receipt of Notice of Privacy Practices:

Please print and sign your name as well as date this form to acknowledge that you have received the Notice of Privacy Practices.

Name:_____

Signature:_____

Date:_____