Allergy Treatment Center of New Jersey, PC

NEW PATIENT FORMS AND INFORMATION

Thank you for choosing the Allergy Treatment Center of New Jersey. We specialize in the diagnosis and treatment of allergic and immunologic diseases. We hope to provide you with courteous, timely and helpful service.

For your first visit, please fill out the following forms as completely as possible.

We believe your time is just as important as ours. In an effort to avoid long waiting times, we do not double book, "squeeze" patients in or take walk-ins. We ask for your cooperation to ensure you are seen in a timely fashion.

- **Please confirm your appointment**. Our automated system calls and texts appointment reminders 2 days before appointments with Dr. Mumneh. If we have not heard from you, we will try calling again the day before your appointment. **Unconfirmed appointments may be given away to patients with urgent medical problems, especially during allergy season.**

- **To cancel or reschedule your appointment, please call us *at least* 24 hours prior to your appointment.** Failure to cancel appointments at least 24 hours prior to the appointment will result in a missed appointment charge or your appointment may be given to someone else. This fee must be paid before you can make another appointment.

    - Missed New Patient Appointment: $50
    - Missed Established Patient Appointment: $35
    - Missed Allergy Test Appointment: $75

- **Please arrive a few minutes early** to all appointments as we may need you to update your contact and **insurance** information. This information must be entered before the doctor sees you.

- **Please bring to your appointment**

    - **your insurance card and drivers license (or other photo ID and proof of address).** We need your ID and proof of address (electric bill, phone bill, etc.) to prevent identity theft.
    - **your insurance referral, if your insurance requires it.** Most insurance companies do not accept a note or prescription from as a referral. You must have the appropriate form with an authorization number issued by the insurance company.

  You will not be seen without these and your appointment will be considered missed (fees apply).

- **Please do not wait until the last minute to make appointments.** When your allergy or asthma symptoms worsen, call us before it becomes urgent. We have limited evening and Saturday appointments. If you wait, we may not have any appointments at the times best for you, especially during allergy season.

- **If you are late for your appointment, please understand that we may not be able to see you or that you may have a long wait.** We will try to accommodate you if you are late, but we cannot guarantee if and when you will be seen. Patients more than 15 minutes late will be considered missed appointments (fees apply).

- **If we are running behind schedule, please be patient**. Rarely, we have a complicated patient whose appointment takes longer than expected or we have a patient who has had an allergic reaction to their allergy shots. This may mean waiting 15 to 20 minutes longer than expected.

530 Green Street · Suite 2 East Iselin, NJ 08830 *fax:* 732.283.3042 *tel:* 732.283.3040
1100 Centennial Avenue · Suite 202 Piscataway, NJ 08854 *fax:* 732.562.1770 *tel:* 732.562.1717
Nayla Mumneh MD FAAAAI FA
Diplomate, American Board of Allergy and Imm

Patient Name: _____ Chart #: _____
First Mid. Initial Last

Demographics
(please print)

Patient's Name: _____ ☐ Male ☐ Female
First Middle Last

Are You? ☐ Single
☐ Married /Civil Union
☐ Widowed
☐ Legally Separated
☐ Divorced

Birth Date: _____

Soc. Sec. # _____

Home Address Street _____

City: _____ State: _____ Zip: _____

Home Ph: _____ **Cell Ph:** _____ **Work Ph:** _____

Email: _____ (for email reminders & online patient portal)

Work Status ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Student (Full Time) ☐ Student (Part Time)
☐ Retired ☐ Disabled

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Language(s): _____

Race: ☐ American Indian ☐ Black / African American ☐ White
☐ Asian ☐ Pacific Islander ☐ Other: _____

Patient's Primary Care Physician: _____ Phone: ( ) _____

Address: _____
Street City/State/Zip

Referring Physician: _____ Phone: ( ) _____

Address: _____
Street City/State/Zip

How did you find us? ☐ Internet ☐ Insurance Directory ☐ Ad ☐ Physician ☐ Patient-Who? _____

If patient is child below 18 years of age, please fill out the following:

Mother: _____ Birth Date _____ Soc. Sec. _____
First Mid. Init. Last

Home Address (if different from patient): _____
Street City/State/Zip

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell: ( ) _____

Father: _____ Birth Date _____ Soc. Sec. _____
First Mid. Init. Last

Home Address (if different from patient): _____
Street City/State/Zip

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell: ( ) _____

* Please Note: All children under 18 years of age must always be accompanied by a parent to receive medical services. If another adult will accompany the child, we require that a parent provide written permission for that person to make medical decisions on behalf of the child.

Emergency Contact: _____ Phone: ( ) _____
Relation to Patient: _____

Patient Name: _____ Chart #: _____
First Mid. Initial Last

Insurance

Insurance Information

Primary Insurance Co.: _____ Member ID #: _____ Group #: _____

Insured's Name (if not patient): _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. No.: _____ Phone: _____

Home Address (if different from patient): _____
Street City/State/Zip

Employer _____ _____
Address City/State/Zip

This insurance policy requires me to pay: __ nothing __ a copay (due at the time of service)
__ a deductible and/or coinsurance - please fill out Payment Options Form

Secondary Insurance Co.: _____ Member ID #: _____ Group #: _____

Insured's Name (if not patient): _____ Relationship to patient: _____

Birth Date: _____ Soc. Sec. No.: _____ Phone: _____

Home Address (if different from patient): _____
Street City/State/Zip

Employer _____
Address City/State/Zip

This insurance policy: __ covers my primary insurance deductible, coinsurance and/or copay __ requires a copay
__ has a deductible and/or coinsurance - please fill out Payment Options Form

I authorize the release of any medical information necessary to process my insurance claim and assign the payment of medical benefits to Nayla Mumneh, MD.

Signed: _____ Date: _____
(Patient OR parent, if patient is under 18)

__ I do not have insurance or Dr. Mumneh does not participate in my plan. I understand that payment must be made at the time of service. Payment may be made by cash, credit card or check (with photo ID and Social Security #).

Patient Name: _____ _____ _____ Chart #: _____
First Mid. Initial Last

Prescriptions

During your first visit, Dr. Mumneh may prescribe medication(s) for your condition. Prescriptions are sent to the pharmacy electronically. Please provide us with name and location of a local pharmacy as well as your mail order pharmacy.

Pharmacy Name: _____

Location (Street & City):_____ Phone: ( ) _____ _____

Mail Order Pharmacy: _____

Refill Policy

- We will provide **prescription refills to patients who have been seen regularly, at least every six months to a year, depending on your health condition.**
- **If you have missed your follow-up appointment or it has been more than a year since you were last seen, you must make an appointment for an office visit to receive new prescription refills.** This is to ensure that the dosage and type of medications are adequate and that you have no new medical conditions that may affect your treatment or cause drug interactions.

Appointment Confirmation Preferences

We will call and email you to confirm your appointments.

Would you like to receive text message reminders as well? __ Yes __ No

Cell Phone Number: _____

Patient Portal

If you provided an email address on Page 1 of this packet, we will register you for access to our Patient Portal. You will be able to access your medical records, communicate securely with this office, request and reschedule appointments and request prescription refills.

Your username will be your email address. You will receive an email with your temporary password. It will include a link to the Patient Portal Website.

I agree that all the information provided on these forms is correct and true. Should any of the information on this form change, I will update Allergy Treatment Center in a timely fashion.

Signed: _____ Date: _____
(Patient or parent, if patient is under 18)

Patient Name: _____ Chart #: _____
First Mid. Initial Last

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (TPO)

- I understand that as part of my healthcare, Allergy Treatment Center of New Jersey PC (ATCNJ) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this protected health information (PHI) serves as:

  - a basis for planning my care and treatment,
  - a means of communication among the many health professionals who contribute to my care,
  - a source of information for applying my diagnosis and treatment information to my bill,
  - a means by which a third-party payer, such as an insurance company, can verify that services billed were actually provided, and
  - a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

- I understand that I have the right to review ATCNJ's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. This notice is available on our website, www.allergytreatmentcenter.net, or at our offices upon request.

- With this consent, ATCNJ may communicate with me, by telephone, voicemail, mail or email in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements, clinical care, including laboratory test results, among others.

- I understand that I have the right to request restrictions, in writing, as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that ATCNJ is not required to agree to the restrictions requested.

- I understand that ATCNJ reserves the right to change their notice and practices at any time. A copy of the revised notice will be posted on our website.

- I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

By signing this form, I am consenting to allow ATCNJ to use and disclose my PHI to carry out TPO.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable

Patient Name: _____ Date of Birth_____
First Mid. Initial Last

Financial Agreement

Out-of-Network Insurance Coverage OR No Insurance
If we do not participate in your insurance plan or you do not have insurance, you must pay at the time of service.

In-Network Insurance Coverage
We will submit all of your insurance and Medicare claims within a few days of your visit. Please Note: Your health insurance coverage is a contract between you and your insurance company. **YOU are ultimately responsible for payment for any medical services rendered at the Allergy Treatment Center.** In addition:

- Co-payments must be paid before you see Dr. Mumneh, or you will be charged a $10 billing fee.
- **If you have a deductible, coinsurance or limited coverage:**
  - You must make payment arrangements prior to your office visit. You can
    - *Put a credit card on file.* Please see our Payment Options form for details
    - *Pay an estimate* based on your benefits and your insurance fee schedule.
  - If you do not wish to make payment arrangements, there is a $10 monthly statement fee.
- **If your plan requires a referral, you cannot be seen, unless you pay our fee at the time of service.**
  - We cannot wait for referrals, although we will refund any payments you have made if you can provide a valid referral within 3 days of your appointment.
- If your insurance company require you to make any unexpected payments (i.e., we did not know that you have a deductible for certain procedures or your coverage was terminated), we will bill you once without the $10 monthly statement. *Please pay the bill in full or make payment arrangements within 10 days to avoid being charged the monthly statement fee.*
- If we have not received payment within 60 days after we submit a claim, you will be responsible for payment of all charges. If we receive payment from your insurance company, we will issue a refund.

Past Due Patient Balances
- Patient balance more than 30 days past due must be paid in full before future appointments are made. All account balances must be paid in full within 60 days from the date of service, unless you have made formal payment arrangements with our office.
- **Accounts more than 60 days past due will be forwarded to a collection agency.** We will charge you a collection fee of $60 or 30%, whichever is greater.

Other
- We expect payment from the parent/guardian who accompanies a dependent minor to our office. The accompanying parent/guardian will be considered the responsible party. We will not bill a non-custodial parent, even though this may be a part of a divorce agreement. Our office is not part of divorce agreements between parents. We can provide a paid receipt for services rendered.
- Returned checks and rejected credit cards (on file) are subject to a $25 charge.

Who is responsible for payment? If the patient is a child, this person must be the accompanying parent.

Name: _____ Birth Date:_____
First Middle Last

Home Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip: _____ Work Phone:( ) _____

Social Security # _____ (not necessary if you put your credit card on file)

Signed: _____ Date: _____

Patient Name: _____ Chart #: _____
First Mid. Initial Last

PAYMENT OPTIONS

THIS FORM IS FOR PATIENTS WITH INSURANCE PLANS WITH A **DEDUCTIBLE AND/OR COINSURANCE** (A PERCENTAGE OF THE ALLOWED CHARGES) OR PATIENTS WITH LIMITED COVERAGE PLANS ONLY.

This means you will be required to pay at least a portion of the charges incurred today.

If your plan requires you to pay only a copay (with no deductible or coinsurance), please skip this form.

You have the following options to settle your account balance:

- ❑ **Option 1: I will put a credit card on file.** When we receive a statement from your insurance, we will charge the amount you owe to your credit card and mail you a receipt. We can provide you with an estimate of what you will owe at the time of your visit. You can also set up a payment plan, but this requires that you put a credit card on file. Please note: Credit card numbers are encrypted. We cannot see them after they are entered.

- ❑ **Option 2: I will pay the estimated portion of the charges that I am responsible for today,** based on my insurance company's fee schedule and my benefits. I will continue this arrangement for future visits.

  Please Note: Estimates are not guaranteed. Your insurance company determines your responsibility based on your policy. We will bill you or issue a credit, if necessary. You will not be charged a statement fee for the first statement we send.

Most insurance companies mail detailed statements to policyholders. If you do not receive this statement by mail, you can find explanations about how your claims were processed on your insurance company's website.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable

Patient Name: _____ Date of Birth_____
First Mid. Initial Last

Environmental History

Your Home

What type of home do you live in? ☐ Single Family Home ☐ Apartment ☐ Townhouse / Condo

Age of your home? _____

What kind of heating system do you have? ☐ Forced Air ☐ Radiator ☐ Baseboard ☐ Fireplace /Woodstove

Do you have air conditioning? ☐ Yes ☐ No

What kind? ☐ Central A/C ☐ Window Units

Do you have any air purifiers or filtration systems? ☐ Yes ☐ No

What kind? ☐ Portable HEPA Units ☐ Portable Ionic Units ☐ HEPA Vacuum ☐ HEPA filter in Heating / A/C

What kind of flooring do you have in your bedroom? ☐ Carpet ☐ Hardwood ☐ Tile ☐ Other: _____

Do you have allergen-proof or dust mite covers on your mattress? ☐ Yes ☐ No

Animal Exposures

Do you have any pets? Yes ☐ No

☐ Cats How many? _____ ☐ Dogs How many? _____

☐ Birds How many? _____ What kind? _____

☐ Other _____

Did you previously have pets? ☐ Yes ☐ No Type? _____

Are you exposed to animals in the homes of relatives or friends? ☐ Yes ☐ No

Type of Pet(s): ☐ Cat ☐ Dog ☐ Bird

How often are you exposed? ☐ *Daily* ☐ *Few times per week* ☐ *Few times per month* ☐ *Few times per year*

Work

Occupation: _____

Location: ☐ School ☐ Office ☐ Factory ☐ Medical Facility ☐ Outdoors ☐ Store ☐ Other _____

Occupational exposures: ☐ Chemicals/fumes ☐ smoke ☐ molds ☐ pet dander ☐ dust ☐ pollen

Tobacco

Are you exposed to tobacco smoke? ☐ Yes ☐ No

Who is the smoker? _____

Where is the exposure? _____

For Children Only:

Birth History

Patient was born: ☐ Full Term ☐ Prematurely

After the birth, the patient: ☐ left hospital routinely ☐ was placed in an incubator ☐ needed breathing machines

Growth rate: ☐ normal for age ☐ reduced for age, but following curve ☐ not following curve

Patient Name: _____ Date of Birth _____
First Mid. Initial Last

Allergy History

Have you had allergic reactions in the past? ☐ Yes ☐ No

If yes, to what: Reaction

☐ Food Please List: _____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis
_____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis
_____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis
_____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis

☐ Drug Please List: _____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis
_____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis
_____ ☐ Hives ☐ Rash ☐ Vomiting ☐ Stomach Cramps ☐ Anaphylaxis

☐ Animal ☐ Cat ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ Dog ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ Rabbit ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ _____ ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives

☐ Environmental ☐ Dust ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ Spring Pollen ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ Fall Pollen ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives
☐ Mold ☐ Sneezing ☐ Stuffy Nose ☐ Wheezing ☐ Itchy Eyes ☐ Chest Tightness ☐ Hives

Have you been tested for allergies before? ☐ Yes ☐ No

What kind of testing? ☐ Skin Tests ☐ Blood Tests ☐ Patch Tests When? _____

Positive for: ☐ Grasses ☐ Trees ☐ Dust ☐ Mold ☐ Cat ☐ Dog ☐ Ragweed ☐ Weeds
☐ Foods: _____
☐ Other: _____

Have you ever been treated with allergen immunotherapy (i.e., allergy shots)? ☐ Yes ☐ No

When? _____ For How Long? _____

Did they help? ☐ Yes ☐ No ☐ Unsure

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530 Green St, Ste 2 East, Iselin, NJ 08830 1100 Centennial Ave, Ste 202, Piscataway, NJ 08854

Please do not write in this space

Patient Name: _____ DOB: _____

Why are you here to see the doctor today?

Do you have any of the following symptoms? Please circle

Nasal Congestion Runny Nose Sneezing Post Nasal Drip
Snoring Mouth breathing Hoarse Voice Sore Throat
Fatigue/Irritability Loss of taste/smell Bad Breath

Cough

Wheezing Difficulty breathing Shortness of breath

Sinus Headache Dizziness sinus congestion

Red Eyes Itchy Eyes

Facial Swelling Tongue/Lip Swelling

Rash Where: _____

Hives

Medical History

Have you been diagnosed with any of the following? Please circle all that apply

Anemia
Asthma
Angioedema
Arthritis
Attention Deficit Disorder
Autism
Bronchitis
Cancer
Cataracts
Contact Dermatitis
COPD
Diabetes Type 1
Diabetes Type 2
Drug Allergies
Ear Infections
Eosinophilia
Epilepsy / Seizures
Eczema
Food Allergies
Frequent Childhood Infections
Glaucoma
Heart Attack
Heartburn or GERD (reflux)
Hepatitis A, B or C
Hereditary Angioedema
Hypertension (High blood pressure)
Immunodeficiency
Liver Disease
Migraines
Nasal Polyps
Osteoporosis
Other infections
Pet Allergies
Pneumonia
Seasonal Allergies
Sinusitis
Tonsilitis
Thyroid Disease
Urticaria (Hives)
Vertigo

Are you pregnant? Yes No

Medications

Please list your current medications:

_____ _____

_____ _____

_____ _____

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Please do not write in this space

Please list any allergy medications you have taken in the past:

_____ _____
_____ _____
_____ _____

Known Allergies

Drug	Reaction
_____	_____
_____	_____
_____	_____

Food	Reaction
_____	_____
_____	_____
_____	_____

Other	Reaction
_____	_____
_____	_____
_____	_____

Surgeries? Please list

Social History

Tobacco Use

__ Current Daily Smoker: Please circle < 1 pack/day 1 pack/day
1.5 packs/day 2+ packs/ day

How many years?_____

Do you want to quit? Y N

__ Current Occasional Smoker How many years?_____

__ Former Smoker When did you stop? _____ days ago
_____ months ago
_____ years ago

__ Never Smoked

I am exposed to tobacco smoke at: ___home ___work ____neither

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Please do not write in this space

Immunizations

Have you had a flu shot in the last year? When?_____

Have you had a pneumonia shot in the last five years? When?_____

Family History

Does anyone in your family have any of the following diseases? Please circle all that apply

Anemia
Asthma
Angioedema
Arthritis
Bronchitis
Cancer
Cataracts
Contact Dermatitis
COPD
Diabetes Type 1
Diabetes Type 2
Drug Allergies
Ear Infections
Eosinophilia
Epilepsy / Seizures
Eczema
Food Allergies
Frequent Childhood Infections
Glaucoma
Heart Attack
Heartburn or GERD (reflux)
Hepatitis A, B or C
Hereditary Angioedema
Hypertension (High blood pressure)
Immunodeficiency
Liver Disease
Migraines
Nasal Polyps
Osteoporosis
Other infections
Pet Allergies
Pneumonia
Seasonal Allergies
Sinusitis
Tonsilitis
Thyroid Disease
Urticaria (Hives)
Vertigo

___ I don't have this information because I (patient) was adopted or is in foster care