# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

*Please print your name here*

_____

*Signature*

_____

*Date*

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

*Employee signature* *Date*

**Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

**Fundraising:** We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

**Sale of PHI:** We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

**Appointment Reminders:** We may use your health records to remind you of recommended services, treatment or scheduled appointments.

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Breach Notification Requirements:** It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Bay Shore Allergy & Asthma Specialty Practice, PC  Privacy Officer: Maureen Rigelhaupt

Telephone: (631) 665-2700_____ Fax: (631) 665-0290_____

Email: bsga649@gmail.com

Address: 649 Montauk Highway West Bay Shore, NY 11706

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 01/01/2018 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Maureen Rigelhaupt. Information on contacting us can be found at the end of this Notice.

**We will keep your health information confidential, using it only for the following purposes:**

**Treatment:** While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

**Right to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $____for each page and the staff time charged will be $_____per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

**Right to Request Restriction of PHI:** If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

**Information We Do Not Collect:** We do not use cookies on our website to collect data from our site visitors. We do not collect information about site (www.madisonmed.secure-sage.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data though our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

**Limited Right to use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:** Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Bay Shore Allergy & Asthma Specialty Practice, PC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance information.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send us will ever be publicly used without your direct or indirect consent.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

**Notice of Information Practices and Privacy Statement**
**Bay Shore Allergy & Asthma Specialty Practice, PC**

649 Montauk Highway
West Bay Shore, NY 11706
Phone: (631)-665-2700 Fax (631)-665-0290

**How We Collect Information About You:** Bay Shore Allergy & Asthma Specialty Practice, PC and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance though our organization.

**What We Do Not Do With Your Information:** Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

**How We Do Use Your Information:** Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between MMC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, as well as any other information as permitted by law.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorney or other legal professions, as well as any other information as permitted by law.

# LOUIS E. GUIDA, J.R., M.D.
# BAY SHORE ALLERGY & ASTHMA SPECIALITY PRACTICE, PC

## INDIVIDUAL PATIENT'S AUTHORIZATION

Name of Patient: _____

I. Individual's Responsibility for Non-Covered Services

In consideration of services rendered by Bay Shore Allergy & Asthma Speciality Practice, to the undersigned patient, the undersigned promise(s) to pay Bay Shore Allergy & Asthma Specialty Practice, all co-payments, co-insurances and other charges required to be paid by my health plan coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of same prior to the rendering of said services.

II. Assignment of Benefit Proceeds

I, hereby assign to Bay Shore Allergy & Asthma Speciality Practice, all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payer, governmental agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records

I hereby authorize Bay Shore Allergy & Asthma Specialty Practice, to release to my insurer/HMO/third-party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

Please list the name(s) of people/organizations you are authorizing to receive your medical information (spouse/parent/or child of legal age).

_____

_____

_____

It is, however expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by Paragraph I above, which are not Medically Necessary or improperly billed.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

# LOUIS E. GUIDA, J.R, M.D.
# BAY SHORE ALLERGY & ASTHMA SPECIALTY PRACTICE, P.C.

## OUR FINANCIAL POLICY

Thank you for choosing Bay Shore Allergy & Asthma Specialty Practice, P.C. as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

*Payment is due at time of service.*
*We presently accept cash, MasterCard/Visa, Discover, American Express or money order as payment.*
*We offer payment plans for non-insured patients. All payment arrangements must be made prior to your visit with only the Billing Department. Payments must be made by cash or credit card only.*
*If current insurance information is not supplied at time of visit and insurance denies claims after timely filing limit, patient will be responsible for all charges.*
*It is the patient's responsibility to keep track of all referrals and pre-authorizations.*
*Patients will not be seen without a valid referral, appointments will need to be rescheduled.*
*If insurance company denies a claim for no authorization or referral, the patient will then be responsible for payment in full.*
*Co-payment is due at time of service.*
*If co-payment is not made at time of service, a $15 service charge will be applied to your account.*
*There is a $20 charge for the filling out of any disability forms.*
*There is a $5 charge for the filling out of any school/medical forms.*
*There is a .75 per page charge for all medical record copies.*
*There is a $25 processing fee for any accounts sent to the collection agency.*

Please notify the front desk of any changes in addresses, phone numbers or insurance carriers.

Thank you for your understanding our financial policy.

I have read the above financial policy. I understand and agree to this financial policy.

This financial policy is in effect for one year.

_____ _____

Signature of patient or responsible party Date

## PREVIOUS SURGERIES

| | | | |
|---|---|---|---|
| ◊ None | ◊ Heart Bypass | ◊ Kidney | ◊ Tonsillectomy |
| ◊ Appendectomy | ◊ Heart Stent | ◊ Obesity | ◊ Other: |
| ◊ Breast | ◊ Hiatal Hernia | ◊ Prostate | ◊ |
| ◊ Colon | ◊ Hysterectomy | ◊ Stomach | ◊ |
| ◊ C-Section | ◊ Joint Replacement | ◊ Thyroid | ◊ |

## SOCIAL HISTORY

| | | | | | | |
|---|---|---|---|---|---|---|
| General | Occupation | | | | # of Children | |
| Marital Status | ◊ Single | ◊ Married | ◊ Divorced | ◊ Separated | ◊ Widowed | ◊ Civil Union |
| Alcohol Use | ◊ None | ◊ Occasional | ◊ Daily | ◊ Weekly | What Type? | |
| Caffeine Use | ◊ None | ◊ Coffee | ◊ Tea | ◊ Soda | ◊ Chocolate | |
| Tobacco Use | ◊ Never | ◊ Former | ◊ Occasional | ◊ Every Day | How many? | |
| Drug Use | ◊ Never | ◊ Former | ◊ Occasional | ◊ Every Day | | |
| | ◊ Marijuana | ◊ Cocaine | ◊ Other: | | | |
| Exercise | ◊ None | ◊ Occasional | ◊ Daily | ◊ Weekly | | |
| Type of Exercise | ◊ Walking | ◊ Running | ◊ Gym | ◊ Treadmill | | |

## FAMILY HISTORY

| Please check if a blood relative has had any of the following | | |
|---|---|---|
| ◊ Asthma | ◊ Diabetes | ◊ Kidney Disease |
| ◊ Hay fever | ◊ Tuberculosis | ◊ High Blood Pressure |
| ◊ Hives | ◊ Stroke | ◊ Heart Trouble |
| ◊ Bronchitis | ◊ Arthritis | ◊ Other: |
| ◊ Cancer | ◊ Emphysema | ◊ Other: |
| **PLEASE COMPLETE BELOW** | | |
| Mother | ◊ Living | ◊ Deceased |
| Father | ◊ Living | ◊ Deceased |
| # of Brothers | # Living | # Deceased |
| # of Sisters | # Living | # Deceased |

## REVIEW OF SYSTEMS

## PLEASE CHECK ALL THAT APPLY NOW OR IN THE PAST

| | | | |
|---|---|---|---|
| **Metabolic** | ◊ Weight Loss<br>◊ Weight Gain<br>◊ Thyroid Disease | ◊ Trouble Sleeping<br>◊ Fatigue<br>◊ Diabetes | ◊ Excess Body Hair<br>◊ Changes in Skin Texture<br>◊ Fever(s) |

| | | | |
|---|---|---|---|
| **HEENT** | ◊ Headaches<br>◊ Dizziness<br>◊ Failing Vision<br>◊ Ear Congestion<br>◊ Ears Itching<br>◊ Eyes Itching | ◊ Excess Tearing of Eyes<br>◊ Inflamed Eyes<br>◊ Sinus Trouble<br>◊ Sore Throats<br>◊ Hoarseness<br>◊ Nasal Discharge | ◊ Post Nasal Drip<br>◊ Nose Bleeds<br>◊ Nasal Congestion<br>◊ Frequent Sneezing<br>◊ Ear Infection(s)<br>◊ Trouble Smelling |

| | | | |
|---|---|---|---|
| **Respiratory** | ◊ Frequent Coughing<br>◊ Infected Sputum<br>◊ Excessive Sputum<br>◊ Wheezing - Asthma | ◊ Shortness of Breath<br>◊ Severe Chest Pain<br>◊ Coughing up Blood<br>◊ Tuberculosis Exposure | ◊ Night Sweats<br>◊ Turn Blue (Cyanosis)<br>◊ Other: _____ |

| | | | |
|---|---|---|---|
| **Cardiovascular** | ◊ Palpitations<br>◊ Angina<br>◊ Ankles Swell<br>◊ Heart Murmur<br>◊ Varicose Veins | ◊ Fainting<br>◊ High Blood Pressure<br>◊ Leg Cramps<br>◊ Wake Up Short of Breath<br>◊ Enlarged Heart | ◊ Heart Skips Beats<br>◊ Must Restrict Salt<br>◊ Require 2 or More Pillows When Sleeping<br>◊ Other: _____ |

| | | | |
|---|---|---|---|
| **Gastrointestinal** | ◊ Nausea<br>◊ Vomiting<br>◊ Indigestion<br>◊ Heartburn or Pain | ◊ Excessive Gas<br>◊ Cramps<br>◊ Diarrhea<br>◊ Constipation | ◊ Blood in Stools<br>◊ Mucous in Stools<br>◊ Hemorrhoids or Polyps<br>◊ Black Stools |

| | | | |
|---|---|---|---|
| **Musculoskeletal** | ◊ Muscle Tightness or Spasm<br>◊ Muscle Pain | ◊ Muscle Weakness<br>◊ Arthritis | ◊ Neuritis<br>◊ Gout |



**Continue on to next page...**

## CHIEF COMPLAINT

**1. Describe the reason for your visit and what problems and symptoms you are having.**

_____

_____

## HISTORY OF PRESENT ILLNESS

**1. When did these symptoms begin?**

_____

**2. How severe are the symptoms? (circle one)** **1** **2** **3** **4** **5**
**mild** **very severe**

**3. How often do you have these symptoms?**

_____

**4. Does anything make these symptoms worse?**

_____

_____

**5. Does anything make the symptoms better?**

_____

_____

## PAST OR PRESENT MEDICAL HISTORY

| Please check all that apply to the patient | |
|---|---|
| Pulmonary | ◊ Asthma ◊ COPD ◊ Sleep Apnea ◊ Chronic Cough ◊ Use CPAP or Oxygen at home |
| Endocrine | ◊ Diabetes ◊ Thyroid – Hypoactive ◊ Thyroid - Hyperactive |
| Renal | ◊ Kidney failure ◊ Dialysis |
| Cardiovascular | ◊ Hypertension ◊ Chest pain / Angina ◊ Heart Attack ◊ Irregular Heartbeat<br>◊ Pacemaker ◊ Defibrillator ◊ Congestive Heart failure (CHF) ◊ Stent<br>◊ Mitral Valve Prolapse / Murmur ◊ Anticoagulant Therapy ◊ Artificial Valve |
| GI / Hepatic | ◊ Acid Reflux ◊Ulcer ◊Colon Cancer ◊ Ulcerative Colitis ◊ Crohn's Disease<br>◊ Irritable Bowel Disease ◊ Diverticulitis ◊ Lactose Intolerance |
| Hematology-Oncology | ◊ Cancer What type? |
| Neurology | ◊ Seizure Disorder ◊ Stroke ◊ Paralysis |
| Other | ◊ High Cholesterol ◊ High Triglyceride ◊ Arthritis ◊ Blood Clots ◊ Anxiety<br>◊ Depression ◊ Glaucoma ◊ Artificial Implant _____ |



**Continue on to next page...**

**Bay Shore Allergy & Asthma Specialty Practice, PC**
Asthma, Allergy, Clinical Immunology & Pediatric Pulmonary Specialist
649 Montauk Highway
West Bay Shore, NY 11706
www.bayshoreallergy.com
Tel: 631-665-2700 **Louis E. Guida, Jr. MD FCCP** Fax: 631-665-0290

# NEW PATIENT QUESTIONNAIRE

**Please PRINT clearly and check all that apply. Answer all questions from the patient's point of view.**

| Patient's name (First, Middle, Last | Date of Birth | Home Phone | Cell Phone | Work Phone |
|---|---|---|---|---|
| | | | | |

**Patient's Address (Street, City, State, Zip)**

| Primary Care Physician | Address | Telephone # | Fax # |
|---|---|---|---|
| Referring Physician | Address | Telephone # | Fax # |

| Who completed this questionnaire? | Name & relationship if other than patient. |
|---|---|
| Have any other family members been seen at this office? ◊ yes ◊ no | If so, Who? |

| Race | Gender | Contact Preference |
|---|---|---|
| ◊ White ◊ Black / African American ◊ Hispanic ◊ Asian ◊ Other | ◊ Male ◊ Female | ◊ Letter ◊ Telephone call / Message |

**Preferred Pharmacy Name & Telephone #**

**Allergies:** ◊ No Known Allergies ◊ No Known Drug Allergies ◊ Adhesive tape ◊ Latex ◊ Intravenous Dye
**Known Allergy to:**

| Current Medications | | |
|---|---|---|
| **Name** | **Dose** | **How taken** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |



**Continue on to next page...**

# *PATIENT REGISTRATION*

*(Please complete entire form)*

## PLEASE PRINT

Date: _____

## *PATIENT INFORMATION:*

Patient's Name: _____Date of Birth: _____Age: __
Patient's Address: _____Town: _____
State: _____ZIP: _____Phone #: _____Cell#: _____
Sex: Male: ____Female: _____ Email: _____
Single: _____Married: _____Widowed: _____Divorced:_____
Employer: _____Occupation: _____
Primary Care/Referring Physician: _____
Phone: _____Primary Care Address: _____
Town: _____State: _____Zip: _____

## INSURANCE POLICY HOLDER'S INFORMATION

Name: _____ Relationship: _____Date of Birth: _____
Address: _____ Town: _____
State: _____ZIP: _____Phone#: _____Marital Status: _____
Employer: _____Occupation: _____

## MEDICAL INSURANCE INFORMATION

Primary Insurance Name

_____
Address: _____
City/State/Zip: _____
ID/Policy #: _____
Prescription Drug Plan Name:

_____
Prescription Phone #: _____

Secondary Insurance Name

_____
Address: _____
City/State/Zip: _____
ID/Policy#: _____
Policy Holders Name: _____
Policy Holders DOB: _____
Policy Holders SS#: _____

Dear Patients,

Hopefully this will give you a better understanding of our office policy regarding walk-in hours.

Appointments are for first time patients only. After that no appointment is ever necessary for office visits with the Doctor or for an allergy injection as long as you are a current patient.

"**CURRENT**" means that you have been here within the last three years.

Office hours are listed on our business cards or on our website. You can also call our office and press prompt #2.

**Patients requiring an office visit must sign in by 4:30 PM on Mondays and Thursdays.**

However, you may still sign in for allergy injections until 6:30 PM on these days.

**Patients requiring an office visit must sign in by 2:30 PM on Tuesdays and Fridays**

However, you may still sign in for allergy injections until 3:00 PM on these days.

****Please give yourself enough time to wait the 30 minutes after receiving your allergy shots****

Walk-in hours are mainly for the patient's convenience. You can be seen and treated on the day that you are having a problem, rather than call, leave a message, wait for someone to call you back and then try to give you an appointment that fits into your schedule as well as ours. You can come on a day that suits you instead of waiting until a later time.

We know that your time is valuable, however, because we don't know in advance who will sign in, we cannot have charts pulled, referrals checks, etc. until you come in. This must be taken into consideration as part of your waiting time, as well as the number of people signing in with you or just before you.

Please try to understand that some visits take longer than others due to the severity of the patient's condition and although we try to work as quickly and efficiently as possible some delays and longer waiting times cannot be helped.

We are doing the best that we can to shorten the waiting times for your benefit, as well as ours.

We hope that this information has been helpful to you.

Bay Shore Allergy & Asthma Specialty Practice

**LOUIS E GUIDA, Jr. MD FCCP**
Asthma, Allergy, Sinus & Pediatric Pulmonary Specialist

**Bay Shore Allergy & Asthma Specialty Practice, PC**

649 Montauk Highway
West Bay Shore, NY 11706

Tel: 631-665-2700
Fax: 631-665-0290

www.bayshoreallergy.com

**Monday and Thursday**
Doctor Visits: 12 noon to 4:30 pm
Allergy Injections: 12 noon to 6:30 pm

**Tuesday and Friday**
Doctors Visits: 10 am to 2:30 pm
Allergy Injections 10 am to 3:00 pm

Closed on Wednesday, Saturday & Sunday

***Patients must wait 30 minutes after receiving Allergy Injections.***