Three Village Allergy & Asthma, PLLC

1. Patient Registration Form

Please Print Clearly! **All required fields are indicated with a ***

We do not participate in Workman's Compensation or No Fault.

Today's Date _____

***Last Name**_____ **Middle Name**_____ ***First Name**_____

***Street Address**_____

***City**_____ ***State**_____ ***Zip**_____

***Phone (Res)**_____ ***Phone (Cell)**_____ **Phone (Work)**_____

***E-Mail FOR ELECTRONIC VISIT REMINDERS (Print Clearly)**_____

***SSN**_____ ***DOB**_____ ***Sex**_____ ***Age**_____

***Referring Doctor**_____ ***Phone Number**_____

Fax Number_____ ***Consult Request?** ☐ **Yes** ☐ **No**

***Primary Doctor**_____ ***Phone Number**_____

***Emergency Contact Name**_____ ***Relationship**_____

***Emergency Contact Phone #:**_____

Language_____ **Race**_____ **Ethnicity**_____

***Reason for Visit**_____

_____

Please list any current medications!

1. **Drug**_____ **Dose**_____ **Frequency**_____
2. **Drug**_____ **Dose**_____ **Frequency**_____
3. **Drug**_____ **Dose**_____ **Frequency**_____
4. **Drug**_____ **Dose**_____ **Frequency**_____
5. **Drug**_____ **Dose**_____ **Frequency**_____
6. **Drug**_____ **Dose**_____ **Frequency**_____
7. **Drug**_____ **Dose**_____ **Frequency**_____
8. **Drug**_____ **Dose**_____ **Frequency**_____
9. **Drug**_____ **Dose**_____ **Frequency**_____

Three Village Allergy & Asthma, PLLC

Insurance Coverage Information

Please print clearly!

For GHI and NYSHIP patients, please be aware that you will be charged a co-pay twice for the visit and any procedures you receive.

***1. Primary Insurance Policy Company Name:**_____

Policy #:_____ **Group #**_____

Specialist Co-Pay:_____ ***Do you have a Deductible? Yes ☐ No ☐** (If you don't know call your insurance)

Total Deductible:_____ **Amount Already Paid:**_____

Name of the Insured:_____ **Relationship:**_____

DOB:_____ **SSN:**_____ **Sex:**_____

Employer: _____ **Occupation:**_____

Home Phone:_____ **Cell Phone:**_____ **Other Phone:**_____

2. Secondary Insurance Policy Company Name:_____

Policy #:_____ **Group #**_____

Specialist Co-Pay:_____ **Deductible:**_____

Name of the Insured:_____ **Relationship:**_____

DOB: **SSN:**_____ **Sex:**_____

Employer: _____ **Occupation:**_____

Home Phone:_____ **Cell Phone:**_____ **Other Phone:**_____

***Please provide your credit card information at the time of registration.**

Card #:_____ **Security #:**_____ **Expiration Date:**_____

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*I authorize the release to my insurance carrier of any medical information necessary to process claims for any services rendered by Three Village Allergy and Asthma, PLLC, and I authorize payment of medical benefits to THREE VILLAGE ALLERGY & ASTHMA, PLLC, I also accept full financial responsibility for any service or procedure performed at THREE VILLAGE ALLERGY & ASTHMA, PLLC, that is not covered for by my insurance plan(s). Finally, I authorize THREE VILLAGE ALLERGY & ASTHMA, PLLC to charge my credit card for any services and procedures performed at THREE VILLAGE ALLERGY & ASTHMA, PLLC and any collection agency costs if necessary.

***Signature:**_____ **Date:**_____

Three Village Allergy & Asthma PLLC

Patient consent for use and disclosure.

Protected health information.

With my consent, Three Village Allergy & Asthma, PLLC. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Three Village Allergy & Asthma, PLLC reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to Three Village Allergy & Asthma, PLLC Privacy Officer at 3771 Nesconset Highway, Suite 105, South Setauket N.Y. 11720. With my consent, Three Village Allergy & Asthma may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Three Village Allergy & Asthma, PLLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements.

With my consent, Three Village Allergy & Asthma, PLLC may e-mail to me appointment reminders and patient statements. I have the right to request that Three Village Allergy & Asthma, PPLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Three Village Allergy & Asthma, PLLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my previous consent. If I do not sign this consent, Three Village Allergy & Asthma, PLLC may decline to provide treatment to me.

Notice of Private Practices

I acknowledge that I have either been given a copy of the Notice of Privacy Practice (dated 01/31/03) or given the opportunity to review such. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____

Date

PLEASE LIST ANYONE WITH WHOM WE MAY DISCUSS YOUR MEDICAL INFORMATION:

NAME RELATIONSHIP

_____

_____

Three Village Allergy & Asthma, PLLC

Cancellation Agreement

Three Village Allergy and Asthma is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen in a timely fashion.

Please call us at **(631) 675-6474** 24 hours prior to your scheduled appointment if there are any changes or cancellations. If prior notification is not given, you will be charged $25 for the missed appointment.

Please sign below to agree to these above terms:

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Date