TINA C. ZECCA, D.O.
ALLERGY & ASTHMA ASSOCIATES
OF MONMOUTH COUNTY
200 WHITE ROAD, SUITE 205
LITTLE SILVER, NJ 07739
(732) 741-8222
(732) 741-6217 fax
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WELCOME TO ALLERGY & ASTHMA ASSOCIATES OF MONMOUTH COUNTY. YOUR APPOINTMENT IS SCHEDULED FOR

PLEASE NOTE THAT IF YOU HAVE ALLERGY TESTING, THIS APPOINTMENT CAN TAKE ABOUT 1-1/2 TO 2 HOURS.

PLEASE BE SURE TO DISCONTINUE* ANY ANTIHISTIMINES 72 HOURS PRIOR TO YOUR VISIT, FOR EXAMPLE ALAVERT, ALLEGRA, BENADRYL, CLARITIN, RYNA-12, RYNATAN, SEMPREX-D, TUSSI-12, TYLENOL SINUS & ALLERGY, ZYRTEC AND ALL OVER-THE-COUNTER COLD MEDICATIONS AND BEPREVE EYE DROPS.

YOU MAY CONTINUE ALL ASTHMA INHALERS AND NEBULIZER MEDICATIONS, SUCH AS XOPENEX, ALBUTEROL, SINGULAIR & PLAIN SUDAFED.

THE FOLLOWING MEDICATIONS SHOULD NOT BE TAKEN 7 DAYS BEFORE YOUR VISIT:

ASTELIN, CLARINEX, PATANOL, PATANESE AND XYZAL.

PLEASE ARRIVE FOR YOUR APPOINTMENT AT LEAST 15 MINUTES BEFORE SO ALL PAPERWORK CAN BE PROCESSED.

THANK YOU, Allergy & Asthma Associates of Monmouth County

PATIENT REGISTRATION FORM

Last Name_____ **First Name**_____ **MI** ____
Home Address _____
City/State_____ **Zip Code**_____
Home Phone#_____ **Cell #**_____
Work # _____ **E Mail Address**_____
Date of Birth_____ **S/S#**_____
Employer Name & Address_____
Primary Dr. name, address & phone#_____
_____
Pharmacy Name, address & phone#_____
_____

PERSON TO BE BILLED, IF DIFFERENT FROM PATIENT

Last Name _____ **First Name** _____ **MI**____
Home Address_____
Phone# _____ **Work#**_____ **Cell#**_____
Relationship to Patient _____ **DOB**_____
S/S#_____ **Employer**_____

INSURANCE INFORMATION

Insurance Co. _____
Address_____
ID #_____ **Group #** _____
Copay_____
Policyholder Name _____
Address_____
S/S No. _____ **DOB**_____
Relationship to Patient_____ **Employer**_____

_____ _____
Signed by Patient or Guardian **Date**

ASTHMA AND ALLERGY ASSOCIATES OF MONMOUTH COUNTY
200 White Road, Suite #205
Little Silver, NJ 07739

PATIENT NAME:

APPOINTMENT DATE:

CHIEF COMPLAINT: (Reason for Visit)

CURRENT MEDICATIONS:

ALLERGY & ASTHMA ASSOCIATES OF MONMOUTH COUNTY
200 White Road, Little Silver, NJ 07739

NAME: _____ ***DOB:*** _____ ***AGE:*** _____

PRIMARY CARE PHYISICAN: _____

PAST MEDICAL AND ALLERGIC HISTORY:

Past Medical History: (i.e., heart attack, bronchiolitis).

Surgeries: (If applicable, please list surgery type and year(s).

Food Reactions: (If applicable, please list all foods and the reaction that occurred.

Drug Reaction: (If applicable, please list all drugs and the reaction that occurred.

Did you ever have a reaction to latex? Yes or No (Please describe your reaction.)

Have you ever been stung by an insect? Yes or No (Please list the insect and describe your reaction).

BIRTH HISTORY (FOR AGES BIRTH TO 18)

Full term: Yes or No

NSVD or C-Section

Birth Weight: _____ pounds, _____ ounces.

Was your child breastfed? Yes or No. If yes, for how long?

Immunizations: Are they up-to-date? Yes or No

ENVIRONMENTAL:

Home or Apartment Length of Occupancy:

Heat: Central/Forced Hot Air/Radiator ***Air Conditioning:*** Central/Window Unit
Humidifer: Central or Separate

Basement: Flooring: Concrete/Carpeting/Tile Is your basement musty? Damp? Does it flood?

Bedroom: Floor: Hardwood/Carpeting/Hardwood w/Area Rugs
Pillows: Regular or Feather Blanket: Regular or Feather

Living Room: Floor: Hardwood/Carpeting/Hardwood w/Area Rugs

Pets: Dog Cat Bird Other: _____ Do your pets go into your bedroom?

SOCIAL:

Occupation: Marital Status: Married/Single/Widowed/Divorced

Smoking: Do you currently smoke? Yes No

If yes, how much do you smoke and for how long have you smoked?

If you do not smoke presently, are you a former smoker?

If yes, how much did you smoke and for how long?

FAMILY HISTORY: Please list any family members with any history of allergies or asthma.

(PLEASE KEEP FOR YOUR RECORDS)
NOTICE OF PRIVACY PRACTICE

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you or to check you out at the reception desk. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorizations. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

AUTHORIZATION FOR DISCLOSURE OF PROTECTIVE HEALTH INFORMATION

Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

_____Myself only
_____My spouse, significant other, or parent (specify name) _____
_____Other (specify name) _____

PLEASE CHECK YOUR CHOICE OF INFORMATION TO BE DISCLOSED

_____ Yes, I give my permission for medical information to be left on my answering system.

Please check if yes.
_____ Lab/Test results
_____ Diagnosis
_____ Prescriptions

_____ No, I do not want medical information left on my answering system.

I, _____, have received a copy of the Notice of Privacy Practice.
Please Print Patient's Name

I understand that I have the right to revoke this authorization in writing to the office manager at the address below.

I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy rule or State law.

_____ _____
Signature of patient or guardian Date

_____ _____
Print name of patient or guardian Date

_____
Relationship to patient

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Tina C. Zecca, DO

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NOTICE OF PRIVACY PRACTICE
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I acknowledge that I have been informed of the new Notice of Privacy Practices under the HIPPA laws provided by the United States Federal Government effective September 23, 2013.

A copy of the HIPPA has been offered to me via e-mail and I have been offered a copy to read in the office setting.

_____
Patient's Name

_____
Patient/Guardian's Signature

_____
Date

☐ I have chosen to have the new HIPPA laws e-mailed to my personal e-mail. Please send this e-mail to _____.

☐ I have declined to have the new HIPPA laws e-mailed to my personal e-mail.

DISCLOSURE RELEASE

I hereby give permission to release information about treatment given by Allergy & Asthma Associates of Monmouth County to my insurance company. I hereby give permission for my insurance company to pay Allergy & Asthma Associates of Monmouth County directly.

I realize that I am responsible for my co-pay, plus any deductible or amount indicated on my explanation of benefits, as patient responsibility. I also realize that if my insurance requires a referral I am responsible for acquiring one. If I fail to provide this office with a valid referral, I am responsible for the entire bill. Unpaid balances over 45 days old will be charged a finance charge of 1.5% per month or 18% per year. If my account is sent to collection, I am responsible for all collection fees. A late fee of $10 may be charged if the co-pay is not paid at the time of visit. A $20.00 charge may be charged for a missed office visit that has not been cancelled within 24 hours. A fee of $10.00 **will be** charged for physical forms for your job, sports, or camp activities. There will be no charge for office notes to another doctor.

Patient Name_____

Signature of Patient or Guardian_____

Social Security Number and Date of Birth of
Patient/Guardian_____

Printed Name_____

Date_____