# NORTH SHORE ALLERGY AND ASTHMA, S.C.

## PROBLEM LIST AND CURRENT MEDICATION LOG

TODAYS DATE:

| | | |
|---|---|---|
| PATIENT NAME: | | DOB: |
| PRIMARY CARE PHYSICIAN: | | PHONE: |
| PRIMARY PHARMACY NAME: | LOCATION: | PHONE: |

| |
|---|
| ANY DRUG ALLERGIES? IF YES, PLEASE LIST: |
| WHAT SYMPTOMS ARE YOU CURRENTLY PRESENTING WITH: |

| | | |
|---|---|---|
| ARE YOU A SMOKER? | YES OR NO | IF YES, HOW MANY PACKS PER DAY? |
| DO YOU DRINK ALCOHOL? | YES OR NO | IF YES, HOW MANY? |
| DO YOU USE RECREATIONAL DRUGS? | IF YES, PLEASE SPECIFY | |

| | | | |
|---|---|---|---|
| HAVE YOU HAD AN INFLUENZA VACCINE RECENTLY? | YES | OR NO | IF SO, WHEN? |

| PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING STRENGTH AND TIME OF DAY USED |
|---|
| 1 |
| 2 |
| 3 |
| 4 |
| 5 |
| 6 |
| 7 |
| 8 |
| 9 |
| 10 |
| 11 |
| 12 |
| 13 |
| 14 |
| 15 |

# NORTH SHORE ALLERGY AND ASTHMA, SC.

**Dr. Parthiv Shah.**

## Patient Registration

FOR OFFICE USE ONLY

ACCOUNT #_____ PREPARED BY _____ DATE _____ OFFICE_____ENTERED INTO SYSTEM BY _____ DATE _____

## Patient Information

Last Name _____ First Name _____ M.I. ___ Date of Birth _____

Address _____ Apt. _____ City _____ St. ____ Zip _____

Home # _____ Work #_____ Cell Phone # _____

Marital Status ___S ___M ___D ___W Gender ___M ___F Language _____ Race _____

Email Address: _____

Emergency Contact _____ Phone # _____ Relationship _____

## Bills Sent To: (must be filled out)

Relationship to Patient _____

Last Name _____ First Name _____ M.I. ___

Address _____ Apt. _____ City _____ St. _____ Zip _____

Home # _____ Work #_____ Cell Phone #_____

## Medical Information

Pertaining to your condition, have you had any of the following? ___Cat-Scan ___X-ray ___MRI ___Bloodwork

Where _____ When _____

Referring Physician _____ Primary Care Physician _____

Is this visit related to a work injury? ___Y ___N If yes, please stop and notify the front office staff.

Pharmacy Used? _____ Pharmacy Location? _____

## Primary Medical Insurance (Including Medicare & Medicaid)

Check One ___ PPO ___POS ___HMO ___OTHER EFFECTIVE DATE _____

Insurance Company _____ Insurance Co. Phone # _____

Ins I.D. # _____ Group # _____

Primary Card Holder _____ Date of Birth _____ __Self __Spouse __Parent/Guardian

Employer of Insured _____ Insured's Work Phone # _____

## 0Secondary Medical Insurance

Check One ___ PPO ___POS ___HMO ___OTHER EFFECTIVE DATE _____

Insurance Company _____ Insurance Co. Phone # _____

Claim Mailing Address _____

Ins I.D. # _____ Group # _____ S.S. # _____

Primary Card Holder _____ Date of Birth _____ __ Self __Spouse __ Parent/Guardian

Employer of Insured _____ Insured's Work Phone # _____

## Tricare Insurance Only

___ Primary ___ Secondary ___ Other Check One ___Standard ___Prime

Patient's Relationship to Policy Holder _____ Is the policy holder ___retired or ___active?

What is the policy holder's rank? _____ Policy Holder's SS# _____

Policy Holder's Name_____ Policy Holder's Date of Birth_____

## Insurance

In order to file claim on the behalf of the patient, we must have a copy of the insurance card and the complete address of where the claim is to be sent. Without this information, you will be billed directly.

We accept Medicare, most major insurance, numerous PPO and managed care contracts. Be aware that your insurance provider may consider some, and perhaps all, of the services provided not medically necessary. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. As a service to you we will submit all claims for charges to your insurance. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral please call our business office at (847) 662-2454.

Having more than one insurance company does not necessarily mean that our services are covered 100%. We may bill your secondary carrier as a courtesy; however, you will be responsible for following up on unpaid claims and any balances after your insurances have cleared.

## Financial Policy

Thank you for choosing our physicians as your allergy and asthma specialists. We are committed to your treatment being successful. Please understand that timely payment of your bill is considered part of your treatment and your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions about fees or our Financial Policy please contact our billing department at (847) 662-2454.

Our Financial Policy is as stated:

- All patients must complete our "PATIENT REGISTRATION FORM"
- All co-pays, co-insurance, and deductibles are due at the time of service.
- Payment of patient balance is due in full at the time of service unless other arrangements have been made. If you cannot make full payments at the time of service please call our business office to make payment arrangements at (847) 662-2454.
- We accept cash, check, Visa, and MasterCard **ONLY**. If paying by check, we will charge a $20.00 fee for all returned checks.
- If any portion of your balance exceeds sixty (60) days, you will be responsible for this amount plus interest hereon at 1.5% per month regardless of your insurance.

Signature X_____ Date_____

(Patient Signature)

## Minor Care Authorization

MUST BE COMPLETED FOR ALL MINOR PATIENTS

I hereby North Shore Allergy and Asthma, S.C

To perform any emergency treatment necessary for

_____ _____

Minor's Name Parent/Guardian's Signature

# North Shore Allergy & Asthma

**Parthiv Shah, M.D.**

1790 Nations Dr #102 Gurnee, IL 60031

1900 Hollister Dr #320 Libertyville, IL 60048

I hereby authorize my insurance benefits to be paid directly to the above assigned physicians for todays and all future services. Realizing I am responsible to pay any non-covered services. I hereby authorize the release of pertinent information to my insurance carrier (s).

_____ _____

Patient Signature/ Guarantor Date

I acknowledge that I have received NSAA's *Notic of Privacy Practices* containing the description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at an address above to obtain current copy.

_____

Patient Named (Printed)

_____

Relationship to Patient

_____

Signature Date

**NORTH SHORE**

**ALLERGY AND ASTHMA, S.C.**

# EXTERNAL RX HISTORY CONSENT FORM

This form entitles Noth Shore Allergy and Asthma. S.C. to access my external prescription history from participating prescription services, as well as transfer my prescriptions electronically to the pharmacy of my choice.

*External prescriptions may include those prescribed by another provider.

Opt In Signature _____

Opt out Signature _____

**1790 Nations Drive, Suite 102**

**Gurnee, IL 60031**

**847-662-4455**

**1900 Hollister Drive, Suite 320**

**Libertyville, IL 60048**

**847-367-1760**

**NORTH SHORE**
**ALLERGY AND ASTHMA, S.C**

# 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

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

This notice was published and becomes effective on/or before April 14, 2000.

***Uses and Disclosures of Health Information***

We use and disclose information about you for treatment, payment and healthcare operations.

**Treatments:** We may disclose your health information to physician or other healthcare providers providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Health Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualification of healthcare professionals, evaluation practitioner and provide performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**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 in the use or disclosure indicated in the authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.