Carmine J. De Fusco, M.D., P.A.

Allergy, Asthma and Clinical Immunology

224 Taylors Mills Road Suite 103 Manalapan, N.J. 07726-3281

Phone {732} 462-0666 Fax {732} 462-0992

Welcome to our office!

In this packet you will find: a **Patient HIPAA Consent & Release of PHI**, **Financial Policy Form** and an **Assessment Form**.

If the patient is 18 years old, or older, they must sign the Financial, HIPAA & Patient Consent Forms. If a parent, or spouse, wishes to <u>also</u> accept financial responsibility for the account then they must sign the lower portion of the Financial Policy form.

The Assessment is 7 pages along, please fill it out completely. If any section does not apply, then please mark it with “N/A.”

Please bring all the completed forms; your insurance card, photo id, co-pay and referral (if required).

If you have any questions please call {732} 462-0666.

We look forward to seeing you.

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Manalapan, NJ 07726-3281
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Adult Assessment Form

Date _____

Patient's Name_____

Address_____

Home #_____ Cell #_____

Contact Preference: Home Cell

E-mail Address _____

Sex: M F DOB _____ Height _____ Weight _____

Smoking Status: Every Day Socially Former Never

Marital Status: Single Married Divorced Widowed

Race: White Asian African American Indian Other

Ethnicity: Not Hispanic Hispanic/Latino Mexican Puerto Rican Other

Primary Care Physician_____

Pharmacy Name & Address_____

Preferred Lab LabCorp Quest CentraState JerseyShore Other

Primary Insurance Carrier _____

Policy Holder's Name _____

Patient's Relationship to Policyholder: self spouse child other

Policy Holder's DOB _____ Effective Date _____ Specialist Copay _____

Group # _____ ID# _____

Secondary Insurance Carrier _____

Policy Holder's Name _____

Patient's Relationship to Policyholder: self spouse child other

Policy Holder's DOB _____ Effective Date _____ Specialist Copay _____

Group # _____ ID# _____

Chief Complaint(s)_____

Have you had these symptoms before? yes no If so, when? _____

When did your symptoms begin? _____

How often do they occur? _____

What do you think causes these symptoms? _____

Do you miss work/school due to your symptoms? yes no

Circle the season(s) when it is most severe: Winter Spring Summer Fall

What body parts are affected? _____

What makes it worse? _____

What makes it better? _____

Activities engaged in prior to the onset of symptoms: _____

_____

List any different/unusual food/drink consumed before the onset of symptoms: _____

_____

List any new/different environmental factors at home or at work: _____

_____

What ALLERGY medications are you taking? _____

What NON-ALLERGY medications are you taking? _____

_____

What medications have you tried previously for your condition?_____

_____

What medications/treatments help the most? _____

_____

ADVERSE DRUG REACTIONS

Date	Drug	Reaction	Has it been used since

ADVERSE FOOD REACTIONS

Date	Food	Reaction	Can it be eaten now?

Circle all the foods you have had a reaction to: dairy eggs soy grains fish meat chocolate shellfish fish vegetables nuts colorings/dyes preservatives none other _____

PREVIOUS MEDICAL HISTORY

Date	Diagnosis	Confirmed by History	Confirmed by Physical Exam	Confirmed by Skin Test	Confirmed by Lab Test

Please list previous surgeries and date performed: _____

_____

_____

LIVING ENVIRONMENT-PLEASE CIRCLE YOUR RESPONSES

Where do you live? house condo townhouse apartment other_____

Age of home? 1-5 years old 6-10 years old 11-20 years old >20 years old unknown

Where is your home located? city suburbs country farm shore

Is your basement? damp dry no basement

Is it your basement? cluttered/dusty clean fully finished partially finished unfinished

What type of heating system do you have? forced hot air baseboard radiator thermal

What type is it? gas oil liquid propane electric

What type of filter? basic furnace filter dense fiber filter permanent electrostatic disposable electrostatic Hepa-type washable filter none

Do you have a humidifier? yes no

If yes, what kind? installed on furnace room steam

What type of air-conditioning do you have? central window wall mount none

Do you have a dehumidifier present? yes no

Do you have potted plants in the home? yes no

Bedding- mattress & box spring mattress only air mattress memory foam

Do you use mattress covers? yes no

If yes, on what? mattress only mattress & box spring

Blankets- wool cotton quilt down comforter hypoallergenic synthetic quilt

Pillows- synthetic down/feather cotton memory foam no pillows

Are your pillows encased in a hypoallergenic covering? yes no

Bedroom Flooring- wall-to-wall carpeting hardwood floors vinyl flooring area rugs

Bedroom Window Coverings- drapes curtains blinds fabric shades

Are you exposed to second-hand smoke in the home? yes no

Do you have pets? _____ If yes, what kind? _____

SOCIAL HISTORY

Occupation_____

student work full time part-time work from home retired do not work

How long have your worked at your job?_____

Are your symptoms worse at work/school? yes no

If yes, what type of symptoms? nasal respiratory skin

Are you exposed to any chemicals or special substances at work? yes no

If so, what? _____

Do you smoke? yes no

If yes, what? cigarettes cigars pipes vape

If no, did you smoke previously? yes no If yes, when did you stop? _____

Do you consume alcohol? yes no

If yes, how much? occasional moderate heavy

Do you consume caffeine? yes no

If yes, how much? occasional moderate heavy

Do you use drugs? yes no If yes, when did you start? _____

If yes, what? marijuana cocaine heroin

If no, did you use them in the past? yes no If yes, when did you stop? _____

Do you exercise? yes no

If yes, what type? yoga Zumba aerobics cardio walking cycling weights

Frequency? occasionally moderate heavy

Do you feel stressed? yes no

marital issues child(ren) health problems of _____

work environment financial problems school

Changes is family situation? yes no

Please list your hobbies & interests: _____

_____

PLEASE MARK ANY FAMILY MEMBERS THAT HAVE/HAD ANY OF THE FOLLOWING CONDITIONS

ILLNESS	FATHER	MOTHER	BROTHERS	SISTERS	CHILDREN	Age When Diagnosed
Hay Fever						
Asthma						
Eczema						
Hives						
Food Allergies						
Drug Allergies						
Emphysema						
Thyroid Disease						
Sinusitis						
Insect Sting Allergy						
Migraines						

How many children do you have? _____ Sons _____ Daughters _____

How many brothers do you have? _____ How many sisters do you have? _____

Your mother's age? _____ Your father's age? _____

CIRCLE ALL THE RESPONSES THAT APPLY

Nose:

Do you have AM nasal congestion? yes no

If yes, does it? slowly improve persist throughout the day

Do you breath through your mouth? yes no

If yes, how often? occasionally frequently constantly

How often do you sneeze? never occasional frequently

Is your nose itchy? never spring summer fall winter perennially

Secretions: none occasionally frequently **Are they**? clear cloudy varies

Where is it worse? home work school indoors outdoors

When is it worse? spring summer fall winter perennially

Do you snore? yes no **If yes, how often**? occasionally frequently daily

Does your palate itch? yes no

Do your symptoms interfere with your sense of: taste smell hearing vision none

Triggers: dust pollen mold smoke dog cat cut grass musty places foods heat

respiratory infections pollution cold air exercise stress menstruation weather changes

Sinuses:

Do you clear your throat? yes no

If yes, how often? occasionally frequently constantly

Do you have post-nasal drip? yes no

If yes, how often? occasionally frequently daily

Secretions: clear cloudy varies none

Do you get sinus headaches? yes no

If so, how often? occasionally frequently daily

Where does your head hurt? face forehead side back entire head

How often do you have sinus infections? never spring summer fall winter perennially

If yes, how many per year? 1-2 3-4 5-6 >6 times per year

If yes, do you usually need antibiotics? yes no

Ears:

Do your ears feel stuffy? never occasionally frequently constantly

If yes, where? right left bilaterally

Do your ears feel like there is water in them? never occasionally frequently constantly

If yes, where? right left bilaterally

Do you have problems with changes in pressure, flying or diving? yes no

If yes, how often? occasionally frequently **Where**? right left bilaterally

Do you have pain in your ears? yes no

If yes, how often? occasionally frequently **Where**? right left bilaterally

Do your ears itch? yes no

If yes, how often? rarely occasionally frequently daily

Did you have ear infections as a child? yes no

If yes, has it continued into adulthood? yes no

How is your hearing? normal mild loss on right mild loss on left mild loss bilaterally

Do you have ringing in your ears? never occasionally frequently constantly

If yes, how often? occasionally frequently Where? right left bilaterally

Lungs:

Do you experience: coughing wheezing shortness of breath none

What medications have you tried? _____

Which ones work the best? _____

Which ones provided no relief? _____

Have you ever been sent to the Emergency Room or admitted to the hospital? yes no

Skin:

Do you have any dermatologic problems? yes no **If yes, what type?** eczema hives both

How often do you have hives? never occasionally frequently daily

When is it worse? winter spring summer fall

What areas are affected? hands arms crease of the arm neck face chest
abdomen back legs feet crease behind the knee

Do your eyes: itch get red watery swollen no

Gastrointestinal:

Do you have gastroesophageal reflux (GERD)? yes no

How controlled is your condition? not controlled partially controlled completely controlled

Do you wake with a bad taste in your mouth? yes no

Have you had significant weight gain? yes no Experienced recent weight loss? yes no

Have you ever had a reaction to insect stings? yes no

If yes, what type of reaction? localized general anaphylactic

Have you ever had a reaction to latex? yes no

Type of reaction? localized general anaphylactic

Have your ever experienced an anaphylactic reaction?

If yes, what was the cause? _____

Do you experience frequent fevers? yes no **If yes, how high?** _____

Do you suffer from cardiac problems? yes no

If yes, what type of problems? high blood pressure high cholesterol high triglycerides

Do you suffer from urinary problems? yes no

If yes, what type of problems? frequency pain burning difficulty with urination

Do you suffer from muscular/skeletal problems? yes no

If yes, what type of problems? pain swelling joint stiffness

Do you suffer from any neurological problems? yes no

If yes, what type? _____

Do you suffer from any psychological disorders? yes no

If yes, what type? _____

Do you suffer from any blood disorders? yes no

If yes, what type? _____

Do you suffer from diabetes? yes no

If yes, what type? _____

Do you have any thyroid problems? yes no

If yes, what type? _____

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Authorization of Benefits

I hereby assign, and authorize payment, directly to Carmine J. DeFusco, M.D, P.A. the medical benefits to which I am entitled under my insurance policy(s). I understand that I am financially responsible to said doctor for charges not covered by this assignment: including, but not limited to my copay, co-insurance and/or deductible(s).

I understand that I am financially responsible to said doctor for charges not covered by this assignment: including, but not limited to my copay, co-insurance and/or deductible(s).

Signature _____

Financial Policy

I understand that my copay MUST be paid upon check-in. Co-pays cannot be billed, this is an insurance company regulation.

If a referral is required, I understand that it is my responsibility to obtain this referral from my primary care physician. The referral must FAXED to {732} 462-0992, before my appointment. I further understand that if the referral is not provided, I will be responsible for all charges related to that visit.

I am responsible for any amount not paid by my insurance company. This amount may be, but not limited to: a copay, co-insurance, and/or deductible. This amount will be billed to me via a monthly statement, after my insurance has been processed & the insurance company has advised Dr. DeFusco's office the total amount of my responsibility.

A "Service Charge" of 2% per month MAY accrue on any balance left unpaid for more than 30 days from my statement date. Any amount left unpaid for more than 90 days will be considered delinquent, be referred to a collection agency, or an attorney, and reported to various credit reporting agencies. If my account is referred to a collection agency, or an attorney, I will be responsible for the payment of any additional fees.

Print Name_____

Signature _____

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Patient HIPAA Consent & Release of PHI

By signing this consent you are authorizing Dr. Carmine J. DeFusco, and the office staff, to use and disclose your personal health information (PHI) to perform routine office operations. Your PHI may be used to: bill and collect payment for services rendered, obtain drug prior authorizations, obtain laboratory results, etc.

You have the right to request that we restrict how your health information is used. We are not required to agree with your request. You may request a copy of our "Notice of Privacy Practices."

You have the right to revoke this consent except where we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing.

Signature_____

Date_____

We are not permitted to disclose/discuss your personal health information (PHI), as per HIPAA guidelines, to individuals other than yourself unless we have written consent on file to do so. **This includes your spouse, parent(s), significant other, etc**. If you wish to provide consent, please complete the form below.

Name_____

Relationship_____ **Tel #**_____

Name_____

Relationship_____ **Tel #**_____

This consent may be revoked by the patient at any time but must be done so in writing.

Thank You!

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Patient Consent

Patient Chart Sharing

By initialing here _____ you give your consent to have the "Patient Chart Sharing" feature enabled in your EHR. When enabled, we will have the ability to automatically exchange your medical records with providers who care for you at connected care locations.

Medication History Authority {we strongly encourage this feature}

By initialing here _____ you grant Dr. DeFusco, and his staff, permission to download the your medication history automatically from pharmacy benefit managers; from "the cloud."

Consent to Call

By initialing here _____ you indicate that you have agreed to receive automated phone calls from Dr. DeFusco's practice on your mobile phone. Depending on the features our practice offers, phone calls may be about appointments, test results, and more.
{mobile #_____}

Consent to Text

By initialing here_____ you indicate that you have agreed to receive automated text alerts from Dr. DeFusco's practice on your mobile phone. Depending on the features our practice offers, text alerts may be about appointments, test results, and more.
{mobile #_____}

Family Billing {only applicable if more than one family member is a patient}

By initialing here _____you indicate that you wish to have this billing feature enabled on your account. A single "Guarantor" is named for the family account; who will then receive a single statement for the entire family, itemized by patient, with details for each transaction. Payments made on the "Family" account are applied to the oldest, open charges first. Enabling this feature greatly simplifies both monthly billing and payments. Family balances are available on check-in screens when you come in for appointments. Payments get applied to oldest balances first so as to keep your account as current as possible. If you have any additional questions, please see Lisa.

Family Guarantor_____
Family Member #1 _____
Family Member #2_____
Family Member #3_____

Not initialing any individual section above, is considered non-consent and that feature will not be enabled on your EHR.

Patient Name _____
Patient Signature _____
Date Signed _____