Elena Resnick MD
New York Physicians, LLP
635 Madison Avenue
New York, NY 10022
212-857-4598

Patient Name: ______________________________
Appointment Date and Time: ______________________________

Doctor: **Dr. Elena Resnick**
Office: **New York Physicians**
Location: **635 Madison Ave, (between 59th and 60th St), 7th Floor**

NOTE: If you must cancel the appointment, please notify us at least 24 hours in advance (212-857-4661) or a missed visit fee may be charged.

A QUESTIONNAIRE has been enclosed. Please fill it out and bring all forms to the visit.

Prior to your visit, please make sure you have **stopped** taking antihistamine medications (ALSO FOUND IN MOST OVER THE COUNTER ALLERGY AND COLD REMEDIES) as follows:

- Benadryl, Diphenhydramine, Chlorpheniramine, Brompheniramine – 4 days prior to visit
- Atarax, Zyrtec, Xyzal, Claritin, Clarinex, Hydroxyzine, Allegra, Rynatan, Vistaril – 1 week prior to visit
- Doxepin, Periactin – 10 days prior to visit

Antibiotics, asthma medication, eye drops, and nose sprays may be continued as usual.

IF YOU CANNOT DISCONTINUE THE MEDICATIONS OR INADVERTENTLY TOOK THEM, YOU SHOULD STILL KEEP YOUR APPOINTMENT.

On the day of your visit, please bring the following items:

1. The completed patient questionnaire
2. Insurance card and completed forms, if necessary.
3. Completed HMO/PPO authorization/referral form(s)
4. Complete name, address and phone number of your referring physician.

Nearby Parking Garages are located on 59th St between 5th Ave and Madison Ave and 61st St between Park Ave and Madison Ave.

WHAT WE DO: We care for all types of allergic problems including asthma, allergic rhinitis (hayfever), atopic dermatitis (eczema), food allergy, drug allergy, hives, insect sting allergy, severe allergic reactions (anaphylaxis), immune system problems and many other allergic and immunologic disorders.

WHAT TO EXPECT:
During your initial visit, expect to meet with the physician to discuss your medical history and to have a physical examination. Allergy tests may be needed, as determined based on the history and physical examination findings. Any tests will be explained in detail before they are performed. Once the problem is diagnosed, treatment options can be discussed. Sometimes an evaluation may need to be continued on another visit in order to complete the diagnostic evaluation and/or to provide medications and detailed information about treatment. We offer comprehensive care that includes an emphasis on education about the treatments for each illness that we treat. You may meet with physicians and support staff, review written and videotaped instructions, and be referred for additional services that are appropriate to your care, if necessary.

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ALLERGY AND IMMUNOLOGY NEW PATIENT QUESTIONNAIRE

Name_______________________________ Date of Birth_______________________

Reason for visit____

Referring Provider____
Address of referring provider ____
____

To whom should we send a report of your visit?__________________________________

Food Allergy History _______ N/A

What foods are excluded from your diet?

____
____

Which of these foods, if any, are not strictly excluded (e.g. has small amounts of an ingredient)?

____

If you have had an allergic reaction after eating certain foods, please list

Food	Date of reaction	Amount of food	Type of exposure (ie. Ingestion, contact, injection)	Symptoms

Have you been skin tested for food allergy before? YES NO
If yes, what were the results? ____
____
When were you tested? ____
Who tested you?____

Have you had blood tested for food allergy before? YES NO
If yes, what were the results? ____
____
When were you tested? ____
Who tested you?____

Please bring test results if possible.

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Please list any foods that are avoided purely on the basis of previous testing or advice (there has never been a reaction or ingestion).

____

Do you have itching in the mouth after eating raw fruits or vegetables?
If yes, please list the fruits or vegetables______________________________

____

Environmental Allergy History ________N/A

Do you have allergic symptoms during certain seasons? YES NO
If yes, which season and what type of symptoms?
Spring ______________________________
Summer ______________________________
Fall ______________________________
Winter ______________________________

Do you have allergic symptoms after exposure to animals? YES NO
If yes, what animal, what symptoms? ______________________________

____

Do you have chronic allergic symptoms? YES NO
If yes, what symptoms? ______________________________

____

Have you had skin or blood testing for environmental allergies before? YES NO
If yes, please summarize or, if possible, bring copies of results.

____

____

Have you had had a suspected allergic reaction to insect stings? YES NO
If yes, please specify ______________________________

____

Have you received allergy shots before? YES NO
If yes, when and where? ______________________________

Asthma History _____ N/A

Please circle how often these occur:

1. How often do you experience symptoms?	2 times a week or less	More than 2 times a week	Everyday	Several times a day
2. How often do you wake up at night?	2 times a month of less	3-4 times a month	More than once a week	Every night
3. How frequently do you use Albuterol and/or Xopenex?	2 days a week or less	More than 2 days a week	Everyday	Several times a day
4. Does the asthma cause any limitation with activity?	None	Minor	Some	Very limited
5. How many times per year do you have exacerbations?	0-1 times a year	2 times a year	3 times a year	More than 3 times a year

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How many times have you needed oral steroids (ie. Orapred, prednisone) in the past 12 months?
____

Have you ever been hospitalized for asthma? YES NO
If yes, have you ever been in the intensive care unit (ICU?) YES NO

Eczema/Atopic dermatitis ______**N/A**

What are the triggers for eczema flares?____________________
____

How often do you bathe?____________________
How long is the bath/shower?____________________
What soap/cleaner do you use? ____________________
What moisturizer do you use?____________________

What medications (topical or oral) have been helpful? ____________________
____

What medications have not been helpful?____________________
____

What have you used to control itching?____________________
____

Has the skin ever been infected, requiring antibiotics? ____________________
____

Drug Allergy History _____**N/A**

If you have had allergic reactions after taking certain medication, please list

Drug name	Date of reaction	Type of exposure (ie. Ingestion, injection)	Symptoms

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Current Medications

Please list all medications you are taking (include does and times):

Name	Dose	Frequency

Reviewed and confirmed by Allergy and Immunology Attending Dr.____________________

History

Please indicate which diagnoses have been made for you:

_____ Allergic conjunctivitis
_____ Angiodema
_____ Bronchiolitis
_____ Deviated septum
_____ Epitasis (nose bleeds)

_____ Hearing problems
_____ Insect allergy
_____ Pneumonia
_____ Chronic sinusitis

_____ Allergic cough
_____ Trouble with smell
_____ Bronchitis
_____ Drug allergy
_____ Food allergy

_____ Hives
_____ Nasal polyps
_____ Recurrent infections
_____ Croup

___ Allergic rhinitis (hay fever)
___ Asthma
___ Contact dermatitis
___ Eczema
___ Frequent upper respiratory infections
___ Immune deficiency
___ Ear infections
___ Seborrhea (cradle cap)

Other Medical History ____________________

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Surgical history (circle if any)

Adenoidectomy Tonsillectomy
Sinus surgery Ear tubes
Other surgical history ______________________________

____
____
____
____

Immunizations

Are your immunization up to date? YES NO
Has there been any adverse reaction to immunizations? YES NO
If yes, please explain ______________________________

	Allergic rhinitis	Asthma	Cancer	Diabetes	Food Allergy	Heart	Immune deficiency	Lupus/other rheumatologic disease	Repeated Infections	Sinusitis	Thyroid	Other
Mother												
Father												
Sister												
Brother												
Other______												

Reviewed and confirmed by Allergy and Immunology Attending Dr.______________________________

Social history

Occupation______________________________
Number of alcoholic beverages consumed per day______________ per week______________
Current Smoker? YES NO Number of packs smoked per day______________
Former Smoker? YES NO Quit Date______________

Environmental history

Home type ______________________________
Basement YES NO
Age of house ______________________________
Years living there ______________________________
Heating YES NO
Air conditioning YES NO

Bedroom flooring? carpet rug tile/hardwood/linoleum

Humidifier in bedroom? YES NO

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Is your mattress covered with a special impermeable enclosure? YES NO

Are the pillow(s) covered as well? YES NO

Pets YES NO
If yes, what type of pet ____________________
Is the pet a housepet? YES NO N/A
Does the pet sleep in your room? YES NO N/A

Pest infestation YES NO
If yes, mice rats cockroach termite

Tobacco smoke exposure in home? YES NO
Tobacco smoke exposure in family/friend home? YES NO

Which questions/concerns are the most important to be address?

____
____
____
____

Thank you for your time in answering all the questions as completely as possible.
Please bring the questionnaire with you to your appointment.

Dr Elena S. Resnick M.D.

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Patient Information

Name ______________________ SSN# ____________ DOB ____________ Sex ________

Local Address ______________________________ City, State,Zip ________________

Home Phone ________________ Day Phone ________________ Email Address ________________

Marital Status ________ Smoker ________ Veteran ________ Primary care Provider ________________

Primary Employer ______________________ Address ______________________

City,State,Zip ______________________ Work Phone ________________

Pharmacy Name and Phone ____

Responsible Party Information (if different from above)

Name ______________________ SSN# ____________________ DOB ________________

Local Address ______________________________ City, State, Zip ________________

Day Phone ______________________ Relationship to patient ________________

Primary Insurance
Name of Insurance ______________________ Policy # ________________

Name of insured ______________________ Group # ________________

Address of Insurance Company ____

I authorize the release of any medical information to my insurer and / or HCFA & it agents to process my insurance Claims. I authorize payment of benefit directly to my physicians on my behalf. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered or later to be determined to be ineligible by my insurance carrier(s). These charges include but are not limited to deductibles, coinsurance, and co-payment on my insurance policy. If the doctor is not participating with my insurance plan or I have not obtained the proper insurance referrals and authorizations, I am responsible to the full bill for all services rendered.

Acknowledgement Form

Notice of Privacy Practices

Effective April 14.2003

This is Acknowledgement form is provided to you as required by The Privacy Rule and related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA")

You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you have received this form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to sign this Acknowledgment Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.

I acknowledge that I have received a copy of New York Physicians LLP Notice of Privacy Practices, as of the date indicated below.

Name of Patient____

Signature of patient____

Date signed ____________________

New York Physicians, LLP
635 Madison Avenue
New York, NY 10022

Signature on File

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to New York Physicians, LLP for services furnished to me by the provider. I authorize and holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature ____

Date____

Commercial Insurance

I authorize New York Physicians, LLP to act as my agent to help obtain payment from my insurance carrier(s) This includes my authorizations to release information to my insurance companies, use this form, or a copy of this form in place of the original, process all insurances submissions and for my insurance carrier to directly reimburse New York Physicians, LLP for services rendered.

I understand that although New York Physicians, LLP will help to process insurance claims, I am responsible for my bill.

Patient signature____

Date____

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To Our Patients:

Medicare and all other insurance carriers have specific regulations regarding services they will cover and services they will not cover. These regulations vary between carriers and are subject to frequent change. Many of the policies exclude medical services, which we feel, are part of providing comprehensive, patient-oriented care. Medicare, for example, does not cover routine preventive care with few exceptions, and may not cover some laboratory testing, physician or other provider services, or other tests if determined to be preventive care, or "medically unnecessary", in Medicare judgment.

Partial summaries of services, which Medicare or other carriers determine, are "non-covered or medically unnecessary" is listed below:

Preventive care (most services)

Almost all-preventive care is non-covered, including your routine annual check-up, although and portion of the check-up devoted to treatment of active medical problems may be covered. In our experience almost every visit should have a component devoted to preventive counseling. Medicare does not cover any portion of a visit devoted to discussion of risk factor reduction or preventive counseling.

Some Laboratory Testing

Many tests can only be performed according to a specific schedule (for example, full cholesterol panels will only reimbursed every 4 months, PAP smears can only reimbursed every 3 years) any test falling outside guidelines these will not be reimbursed.

Some Hospital Visit

Hospital visits by more than one physician per day, or two visits by the same physician in a single day are rarely covered. This means that if your personal physician sees you in the emergency room or the intensive care unit, the visit may not be covered since a staff physician will also see you in the same day.

Other Services
-Travel time for house calls
-Telephone calls-we currently only bill for those calls which are complex, or which substitute for and office visit, although this may change in the future with our notice.
-Computer-based searches of the medical literature
-Conference with other physicians or family members regarding your care.
-Review of outside medical records

There are a variety of other services, which may not be covered, and the list may be Medicare or ant may change the list other carrier at any time, but this will give you an idea of the services, which may not be covered.

Some insurance carriers may, at times not reimburse in full for services provided. These decisions are insurance company specific, and are based upon their own fee schedules and specific policy. Although New York Physicians will assist you by providing back-up documentation to your insurance company, you are ultimately responsible for services rendered. New York Physicians adheres to the Medicare fee schedule for participating providers and Medicare patients are responsible for deductibles and coinsurance applicable for Medicare covered services. However, Medicare patients who elect to have non-covered services are responsible for paying charges

Before signing the attached agreement, please discuss and concerns you may have with your physicians. By signing this agreement, you agree a to be directly and fully responsible for any charges that are not covered by your insurance, whether or not the services are covered explicitly in this agreement, and whether or not the services are deemed to be above the usual and customary charges, medically unnecessary or non-covered.

Read and Accepted ____

Date ____

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635 Madison Avenue • New York, New York 10022
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eresnick@newyorkphysicians.com

Office Hours, Appointments, and Communications

I generally see patients from 8am – 4pm. Please call as early as possible if you need to be seen the same day. The phone will be answered by one of our assistants between the hours of 8:30am and 4:30pm. After hours during the week or rarely if all assistants are occupied you will get a recorded message asking you to leave a message or press "zero" to be connected to the doctor on call through the paging system. If you use the paging system please leave a detailed message including your phone number and if you have not received a call back in 30 minutes please call again. For true emergencies please call the New York Hospital Private Ambulance Service if at all possible and ask to be transported to the NYH emergency room on 68th street and York Ave (**212-472-2222**). On the weekends there is a rotating on call doctor and the office message will have detailed instructions for reaching the doctor on call. All medication refills should be addressed during regular office hours.

You may fax (212-752-2454) the office or email me, however all urgent matters should be addressed over the phone. Also, fax and email are not HIPAA compliant and not a secure means of communication. By choosing to communicate with me via fax or email you acknowledge and accept the risk that your private health information may be compromised. To communicate electronically, please sign up for the New York Physicians Patient Portal where you may view your lab results and communicate with me securely, our assistants can give you information on how to do this.

Annual and Follow-up Exams

Annual Exams should occur once per year and will take at least an hour. You may schedule to have your annual lab work completed before the yearly exam so we can discuss the results on that day. You must be fasting for your annual exam so this is best done in the morning (you may drink water and take all of your regular medications). Follow up exams may be scheduled at any time. Appointments must be cancelled 24 hours in advance or a missed visit fee may be charged.

Fees and Payments

Please be sure to discuss in detail with the staff your insurance situation BEFORE your visit. If we do not participate with your insurance, you are expected to pay in full at the time of the visit and we will submit the claim to your insurance for reimbursement directly to you. Reimbursement is solely at the discretion of your insurance company. We do not participate with Medicare at all, and claims may NOT be submitted to Medicare for any reimbursement. If at all possible we will send you to participating centers for lab work, radiological studies etc.

Patient Name_______________________________________ Date__________________

RECORDS RELEASE AUTHORIZATION

TO ____
DOCTOR OR HOSPITAL

____
ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO

Elena S. Resnick, M.D.
635 Madison Avenue
7th Floor
New York, NY 10022
212 857-4598

FAX: (212) 752-2454

THE COMPLETE HISTORY OF RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM ____________________ TO ____________

NAME__________________________________ DATE____________

ADDRESS____

SIGNATURE________________________ WITNESS________________
(IF RELATIVE, STATE RELATIONSHIP)