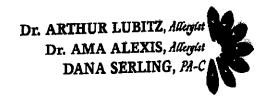
Patient Information Name: _____ D.O.B:___/___/__ Address: _____ Apt. #:____City: _____ State: _____ Zip: ____ Sex: □M □F Marital Status: □M □S □D □W □O Mobile#: (____) _____ Home# :(____) _____ Work#: (____) _____ Currently employed? Output Email: Physician Name or Referring: ______ Address: _____ State: _____ City: ____ Zip: ____ Phone:(____)____ **Insurance Information** Insurance Name: _____ Policy #: _____Policy Holder: _____ D.O.B:____/____Relationship to Patient: ______ Employer: _____ Secondary Insurance: □Yes □No Insurance Name: _____ Policy#:______Policy Holder Name:_______D.O.B:____/___ <u>Pharmacy Info:</u> Name: _____ Phone# :(____) ____ Address: I authorize the release of medical information necessary to communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional costs. I authorize direct payment of covered benefits to the provider of services. The patient is responsible for all fees, regardless of insurance coverage. Payment for office visits is expected at the time of service. Credit cards may be used.

Name:Age:Sex: M/F	Do you have reactions to?			
Why are you seeing us? (Please Describe)	□Aspirin □latex rubber □insect stings			
	□Sulfites □fo	od/additi	ves □plar	nts
	□Medications □vaccines □other			
	□Soaps/fabri	cs soften	ers/cosm	etics
Circle if you have any of the following?	Tell us about your environment:			
Snoring / Coughing / frequent sneezing	Any health co	onditions	;	
Asthma / Bee sting reactions / Rashes / Eczema	Home	Pets	Flooring	
Itchy or watery eyes / Wheezing/shortness of	□House □Apt	□None □Cats	□Wood □Carpet	□Mice : □roaches
Breath/nasal congestion/ Runny nose/ sinus	□Basement	□Dog	□Rug	0
Infection / bronchitis / Yellow or green nasal		<u> </u>	<u> </u>	
Drainage/ reaction to Food or drugs	Mold	Feather	He	ating/AC
Symptoms occur most often:	□Basement □Bathroom	□Pillow □Comfo	-	lot Air ladiant
□Spring□Summer	□None	□None	□C	Central
□Autumn □Winter□ Year around		·		
Symptoms worsen/change with:	Social Histo	ry:		
□Aerosoi Sprays □ Cold air □ Plants	Occupation: Work expos			
□ Cigarette Smoke □ Cosmetics □ pets	Skin sensitiv	ities:		
□ Cleaning □ Chemicals □ Fresh cut grass	Alcohol usa	ge:		<u>:</u>
□ Colds/flu □ Fragrances □ Hot weather				
List your current medications:	Family Hist	ory:	u baalsb	conditions
1	Allergies or			
2				<u> </u>
3 4			,_,	
5.				
6.				
Immunization Status: Are your vaccines up-	Other:			



Patient Consent Form

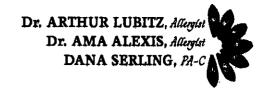
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

The patient understands that:

- · Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:					
	Printed Name (Patient or Representative)				
	Signature	//			
Relationship to Patient (If other	than Patient):				
Witness:	Printed Name (Practice Representative)				
	Signature	//			



Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our financial fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

If you provide our office with the necessary information regarding your insurance plan, we will submit our claim directly to your carrier. YOU ARE RESPONSIBLE TO PAY THE APPROPRIATE CO-PAYS, DEDUCTIBLE AND/OR CO-INSURANCE. We accept cash, personal checks and VISA/MASTERCARD.

REGARDING INSURANCE:

If your plan requires authorization from primary physician, it is your responsibility to obtain the written referral or authorization number prior to your visit with the doctor. If you arrive at our office without prior authorization, full payment will be expected at time of service and refunded to you when authorization is obtained.

Insurance is a contract between you and your insurance company. In most cases, we are **NOT** party to this contract. We file insurance claims as a courtesy to our patients. We will **NOT** become involved in disputes between you and your insurance company regarding deductibles, co-insurance, co-payments, referrals, "usual & customary charges", etc., other than to supply factual information as necessary. If you have not paid the doctor and your insurance company inadvertently pays you directly, you must send this payment immediately to the doctor. You are responsible for the timely payment of your account including all non-covered services.

MEDICARE PATIENTS:

You are responsible for a <u>yearly deductible of \$140 and the 20% portion</u> not paid my Medicare. If you have supplemental coverage, we will submit the claims for you. If you are enrolled in a Medicare HMO (Hip, Oxford, US Healthcare, etc), it is your responsibility to inform our staff. If the appropriate referrals are not obtained full payment will be respected at time of service.

		/	<i>'</i>
RESPONSIBLE PARTY SIGNATURE	DATE		

215 West 57th St. Sullo 509 New York, NY 10019

ARTHUR M. LUBITZ, MD, PC HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX **CONSENT FORM**

Patien	t	MI	2N	Pati	ient	ID:

Please Fax signed consents to: 917-829-2096

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION. Your Consent Choices. You can fill out this form now or in the future. You have the following choices: Please Check I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of my electronic health information through the NYULMC HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care. 2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access my electronic health information through the NYULMC HIE or HEALTHIX for any purpose, even in a medical emergency. NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law. Patient Date of Birth **PRINT Name of Patient**

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Arthur M. Lubitz, M.D., P.C., FAAAAI

DIPLOMATE, ALLERGY AND IMMUNOLOGY

AAI goe enus
eroor yu hoy we/
Dana Serling, PA-C

1.

Ama Alexis, M.D., FAAP

DIPLOMATE, ALLERGY AND IMMUNOLOGY

Allergy and Asthma
315 West 57th Street
Suite 309
New York, New York 10019
Tel: (212) 247-7447 Fax (212) 307-0865
www.mdallergy.com

NETWORK AND HOSPITAL AFFILIATIONS

Dr. Arthur Lubitz, Dr. Ama Alexis and Dana Serling, PA-C are participating physicians with the following care plans:

Aetna – Aetna Students Plan – Affinity Medicaid CHPS – Affinity Medicare Advantage - Affinity HIX - Allied Benefits System Inc. – AARP - Blue Cross and Blue Shield – Blue Card- Blue Federal – Careington (PHCS) - Carpenters Welfare Fund - Cigna – Cigna International - Consolidated Health Plan – Core Source – Coventry Health care - Empire Plan - Fidelis Medicaid – Fidelis HIX- First United American Life GHI Emblem Health - Global Care Inc. - Great West Healthcare – Harvard Pilgrim Healthcare – Health Republic – Health partners - HIP - Health First Medicaid - Health First 65 - Health First HIX-Health Plus – Magnacare – Metropius – Medicare – Meritain Health – Montefiore CMO – Multiplan – Nippon Life Benefits – Oscar – Oxford HMO/PPO - Pointers Cleaners Welfare - Pomco Multiplan – Qualcare – Select Benefits Administrators - Travel Care Services - Travel Guard - Tricare for Life - United Healthcare - United Healthcare Community – United Healthcare Medicare Complete - UMR Insurance - 1199 National Benefit – 1199 Staff Workers – Wellnet Meritain Health – Wine Liquor Distillery Union

Their hospital affiliations are as follows:

Dr Arthur Lubitz: Mount Sinai St Luke's, NYU Langone Medical Center, Lenox Hill Hospital

Dr Ama Alexis: Mount Sinai St Luke's, NYU Langone Medical Center, Bellevue Hospital

Acknowledgement of Receipt:	•	
Signature	Date	
If Legal Representative, Indicate relationship to Patient		
Print Name of Patient		
Print Name of Legal Representative		