Allergy, Asthma, Rheumatology
ASSOCIATES, PC
5793 Widewaters Parkway, Suite 250
Syracuse, New York 13214
Phone: 315-478-2339 **FAX: 315-478-0439**

MICHAEL G. SHEEHAN, M.D.
Allergy /Immunology

HARCHARAN SINGH, M.D.
Allergy /Immunology

Certified by the American Board of Allergy and Immunology

Welcome to our practice!

*It is our pleasure to serve you! AARA is a subspecialty practice dedicated to the treatment of allergic and immune related diseases in the CNY area. Our physicians are **certified** with The American Board of Allergy and Immunology. You can find more about us on our website, **www.aaracny.com***

Name of Patient: _____ Date of Birth:_____

Appointment with Dr._____ Appt. Date &Time:_____

NEW PATIENT APPOINTMENT CHECKLIST

1. PLEASE bring your insurance card. If a referral is required, make sure it is in place *prior* to your appointment. Bring Cash, Check, or Credit Card for co-payments, co-insurance, deductibles.
2. **PAYMENT IS EXPECTED AT DATE OF APPOINTMENT.** Estimated amount $_____, call if you are printing these forms. Additional charges: breathing tests or Allergy testing if done.
3. ARRIVE 15 MINUTES EARLY to allow time to complete any paperwork not mailed to you.
4. If you want us to review any labs done at another physician's office, bring copies of lab reports.
5. We CANNOT promise testing will be done on the first visit.
6. Please do not bring children to your appointment, unless the child is the patient.
7. Bring a list of ALL medications and include name, strength and dosage of all medications.

Please bring this checklist with you to the appointment.

GENERAL INFORMATION

- Daytime phone: (315) 478-2339 Fax: (315) 478-0439
- HOURS 8AM - 5PM: Monday, Tuesday, Thursday, Friday.
- CLOSED FOR LUNCH: 12:00-12:30
- Closed Wednesday, with some holiday exceptions.
- INJECTION CLINIC: Open Monday, Tuesday, Thursday from 8:00-4:15PM.
- You must be signed in by 4:15PM or you will be asked to return.
- AARA physicians are always on call after hours. Dr. Sheehan and Dr. Singh may be reached on beeper. Emergencies only please.
- Call (315) 478-2339 for beeper #.
- A minor less than 18 years old must be accompanied by a Parent/Guardian.
- **if a parent can not be present**, the parent needs to comply with office policy and complete "Designation to permit another person to consent for Health Care". We can provide you the form upon request.
- We strongly advise that you keep your follow-up appointments. **Patients who do not cooperate with us or our policies should not expect optimal results.** **Initial please** _____

- We ask that you notify us of any prescriptions refills you need at the time of your visit.
- Patients who do not keep appointments, will be asked to schedule one before a prescription is refilled.
- A patient not seen within 6 months may be asked to schedule an appointment before any forms including school forms are processed.

AARA's FINANCIAL POLICY

- **If you have no insurance or we cannot verify insurance, full payment is due at the time of the visit.**
- **Patients with balances may be asked to reschedule non-urgent visits until payment has been made.**

ALLERGY, ASTHMA, RHEUMATOLOGY ASSOCIATES ask for the courtesy of 24 hours notice to cancel a scheduled appointment. We reserve the right to charge $30 fee for "NO SHOW"patients who fail to give 24 hour notice. This charge is not covered by insurance.

- We participate in the following plans: AARP Medicare Complete UHC, AETNA, EXCELLUS BC/BS, CDPHP, CHAMPVA, CIGNA, FIDELIS, HUMANA, INDEPENDENT HEALTH (PPO), INDIAN HEALTH SERVICES, MARTIN'S POINT, MULTIPLAN, MVP, NATIONAL GOV'T SERVICES, UMR, UNIVERA, VA, WELLCARE, UNITED HEALTH CARE, as well as, several smaller plans.
  If you do not see your insurance carrier listed, please contact them to inquire about our participation. This listing may change without notice. Please note that our relationship is with you and not with the Insurance Company.
- We do not participate in Medicaid FFS (Fee for Service). If you have Medicaid FFS as a secondary insurance and your primary insurance does not fully cover the fees, you will be held responsible for the balance.
- **It is always the patient's responsibility to make sure that necessary referrals are in place and insurance information is correct and up to date.** If it is not, or we cannot verify such information, we reserve the right to reschedule the appointment or you may be held responsible for payment.
- **All co-pays and/or deductibles are due at the time of service. If you have not met your deductible, payment in full is due at time of service.**
- If you are experiencing financial hardship, please contact us. We will be happy to discuss a payment plan with you.
- Please allow 3 business days to process prescriptions. Please allow 10 business days to copy records.

Allergy, Asthma, Rheumatology Associates reserves the right to discontinue

our professional relationship with you, if our policies are not followed.

I have reviewed and understand Allergy, Asthma, Rheumatology Associates' Office Policies of the Office. I will follow the Office Policies to the best of my ability. This notice is also available on our website.

Print Patient Name:_____ Date_____

Signature of patient (or parent, if patient is a minor)

_____ Relation_____

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PATIENT INFORMATION FORM

NAME(FIRST)_____(MI)_____(LAST)_____

DOB ____/____/_____AGE_____ GENDER: M / F / GENDER IDENTITY:_____

MARITAL STATUS: S /M /W /D SPOUSE'S NAME_____

ADDRESS: _____

CITY_____STATE_____ZIP_____

PHONE:HOME_____WORK_____CELL_____

EMAIL:_____ SS#:_____

PRIMARY PHYSICIAN_____

ADDRESS:_____

REFERRING PHYSICIAN_____

ADDRESS:_____

RESPONSIBLE PARTY:CHECK IF SAME AS ABOVE_____

NAME(FIRST)_____(M)_____(LAST) _____

RELATION TO PATIENT_____ SS#:_____

ADDRESS: STREET _____

CITY_____STATE_____ZIP_____

PHONE HOME_____WORK_____CELL_____

DATE OF BIRTH:_____

EMPLOYER_____

INSURANCE INFORMATION:

	PRIMARY	SECONDARY
COMPANY	_____	_____
ADDRESS	_____	_____
ID#	_____	_____
GROUP#	_____	_____

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PATIENT CONSENT FORM

Please list the family members or other persons with whom we may inform about your general medical condition and discuss your medical condition in an emergency situation, including diagnosis, treatment and other health care information including payment. (It is not necessary to list your primary care physician.)

PrintName:_____ PrintName: _____

Phone:_____ Phone_____

Relation:_____ Relation_____

I, _____, hereby authorize Allergy, Asthma, Rheumatology Associates (AARA) to release all information necessary to complete insurance forms and to secure payment. I also authorize payment for all surgical/medical services to be sent directly to AARA. I accept responsibility for all medical charges not covered by insurance. Initial_____

I agree to pay any co-pays and/or balances at the time of services unless other arrangements have been made in advance. Initial_____

Correspondence regarding medical charges will be sent to the address of the insurance holder unless other arrangements have been approved in advance. I assume responsibility for all reasonable collection costs, including attorney's fees.

I authorize AARA to send correspondence to the address I have placed on record and to leave messages on my telephone answering machine/voice mail pertaining to appointment, payment issues, test results or other personal care information unless I have provided alternative contact information in advance.

I understand and acknowledge that members of AARA, as well as its employees will have access to my/the patient's medical information as reasonable necessary to carry out continuity of care, treatment plans and recommendations, payment activities and health care operations (including, but not limited to, quality assurance activities and audits). I consent to the release of any medical information about me (and any other individuals for whom I can give consent) to my health plan and any health care providers involved in caring for me, or to such individuals as reasonably necessary for my health plan or my providers to carry out treatment, payment or health care operations.

Patient
(or parent)_____Date_____
(Sign)

Relationship:_____

Nov. 11, 2019

The word "patient is specifically used in the statute, and therefore it is questionable whether a non-parent legal guardian has the power to delegate authority to a designee under the law. General obligation Law 5-1551 Parents may appoint a designee for minor children, as well as, incapacitated children. If a court has ordered that both parents must agree on health care decisions, both parents must sign this designation.

Parents Designation to Permit Another Person to Consent for Health Care

1. I/We hereby state that we are parents(s) of the child(ren) named below and there are **NO COURT ORDERS now in effect that would prohibit the exercise of the power which I/WE now seek to authorize.**
2. This designation shall permit _____, (designee) to give consent for health care services for the following individuals:

_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth
_____	_____
Name	Date of Birth

3. This designation shall be valid from _____until and including_____.

4. As to the above named child(ren), the designee is authorized to:

_____ Consent to Immunizations

_____ Consent to general health care, including examinations and treatment

_____ Consent to dental care

_____ Consent to developmental screening

_____ Consent to mental health examination and/or treatment

The designee's authority is limited as follows:

_____

_____

5. **Revocation: I understand** that this designation shall be revoked by any of the following:

a. A parent may revoke a designation by notifying the healthcare provider either verbally or in writing, or by any other act evidencing a specific intent to revoke the designation, or by executing a subsequent designation.

b. If both parents have signed this designation, and either of the parents revokes it, the authority of the designee is revoked.

c. A designee must notify all appropriate health care providers of any revocation of his or her authority.

d. If the parent who signed a designation becomes incapacitated or dies, the designation is revoked.

_____ _____

Parent's signature Date

_____ _____

Parent's name (Please Print) Telephone Number

_____

Patient's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in

his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

_____ _____
Parent's signature Date

_____ _____
Parent's name (Please Print) Telephone Number

_____
Patient's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____
Notary Public

_____ _____
Designee's signature Date

_____ _____
Designee's name (Please Print) Telephone Number

_____
Designee's Address

On this_____day of _____, 20____, before me the undersigned, a Notary Public in and for said state, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

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ALLERGY, ASTHMA, RHEUMATOLOGY ASSOCIATES (AARA) WANTS TO KNOW HOW WE WERE SELECTED AS YOUR ALLERGY/IMMUNOLOGY TEAM?

DOCTOR YOU ARE SEEING: Dr. Michael Sheehan_____

Dr. Harcharan Singh_____

NAME:_____DATE:_____

1.) What made you choose AARA?

a.)_____Physician Referral? Name of Doctor_____

b.)____ Word of Mouth? Name of Friend/Relative_____

c.)_____ Phonebook, "YP", Yellow Pages, Superpages, THRYV, Internet

Search: Words you typed to search_____

_____ Website: www.aaracny.com
_____ Safari
_____ Google
_____ Bing
_____ Yahoo
_____ Maps
_____ Instagram "@5793"
_____ College Referral, Name of University Infirmary _____
_____ Veteran's Association
_____ SELF Referral
_____ Other _____

2.) Have you ever visited our website: www.aaracny.com? _____

3.) Did the WEBSITE help you understand who we are and what we do? _____

4.) Tell us what you liked about it:_____

_____

5.) What would you like to see on it/What needs work?_____

_____

Media Survey, October 2019

Thank you!

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NAME: DATE: AGE: DATE OF BIRTH:
CHART#:

STATEMENT OF CURRENT PROBLEM

PAST MEDICAL HISTORY
1. ILLNESSES:

ALLERGY TO MEDICATIONS:

ALLERGIES TO FOOD:

CURRENT MEDICATIONS

HOSPITALIZATIONS/SURGERIES:

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FAMILY HISTORY:

CHART#_____

DO YOU SMOKE? Y N

PACKS/DAY? _____ # YEARS_____

REVIEW OF SYSTEMS(circle all that apply)

SKIN	CARDIO	PULMONARY	GI	GU	MS	NEURO	CT
Itching	Chest pain	Cough Wheezing	Difficult to Swallow	Pain on Urinating	Joint pain Limited Movement	Headache Double Vision	Dry Eyes
Swelling	Palpitations		Heartburn	Kidney Pain	Joint swelling	Blurry vision	Oral Ulcers
Red Rash	Swollen Ankles	Short of Breathe	Nausea	Blood in Urine	Morning Stiffness	Light hurts eyes	Tongue swell
Dry/Flaky	Fainting		Vomiting				Facial Swelling
Burning	Sev.Dizziness	Pain on Breathing	Acid taste in mouth	Testicular Pain		Ringing in Ears	Neck Pain
Blisters			Diarrhea	Vaginal Discharge		Hearing Loss	Back Pain
Ulcers	Dizzy when standing	Chest Tightness	Constipation		Muscle Pain Weakness		Hand Pain in cold weather

ENT:

Congestion Sneezing Itching Runny Nose Post Nasal Drip Ear Pain/Illness

CONSTITUTIONAL:

Fever Chills Malaise Weight Loss Eye Itching Anorexia Bulimia

HOME ENVIRONMENT:

Age of Home:_____

Location (Circle one):

Rural

Urban

Suburban

Pets in the House? Yes No

SMOKERS in the House: Yes No

Basement: Damp? Yes No

How Heated?

A/C? Yes No

Central Air? Yes No

Portable? Yes No

What room? _____

Dog(s)_____

Cat(s) _____

Other_____

Dehumidifier? Yes No

Pillow: Feathers Cotton

Comforter: Feathers Cotton

Air Purifiers? Yes No

Central Air? Yes No

Portable? Yes No

What room?_____

How often is Bedlinen washed: 1x/week
2x/month
1x/month

Do you wash in: HOT WARM COLD

Bedroom Floor:

Carpet? Yes No

Hardwood? Yes No

Area rug? Yes No

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From the North
Take I-81 South toward Syracuse
Take exit #29S onto I-481 South toward Dewitt
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street
Turn right on Bridge Street
Turn left on Widewaters Parkway

From the South
Take I-81 North
Take exit #16A onto I-481 North toward Dewitt
Take exit #3W and merge onto Rt. 5 West/Rt. 92 West/East Genesee toward Dewitt
Turn right to follow Rt. 5 West/Erie Blvd. East
Turn right on Kinne Road
Turn left on Widewaters Parkway

From the West
Take the I-90 East
Take exit #39 onto I-690 East toward Syracuse
Take exit #16-17/Rt. 635
Turn right onto Bridge Street
Turn left on Widewaters Parkway

From the East
Take I-90 West toward Buffalo
Take exit #34A onto I-481 South toward Syracuse
Take exit #4 onto I-690 West toward Syracuse
Take exit #17/Bridge Street , turn right on Bridge Street
Turn left on Widewaters Parkway